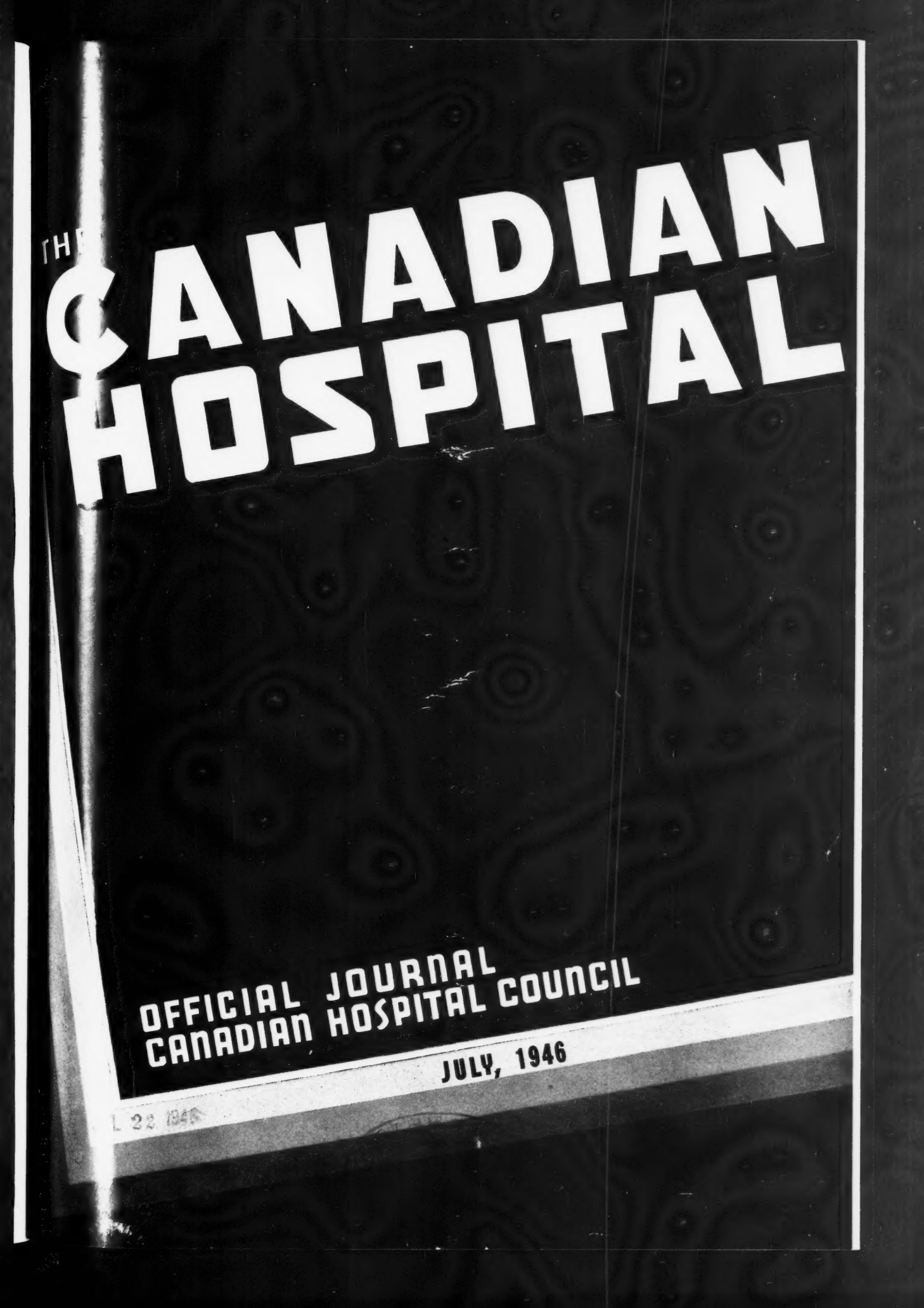
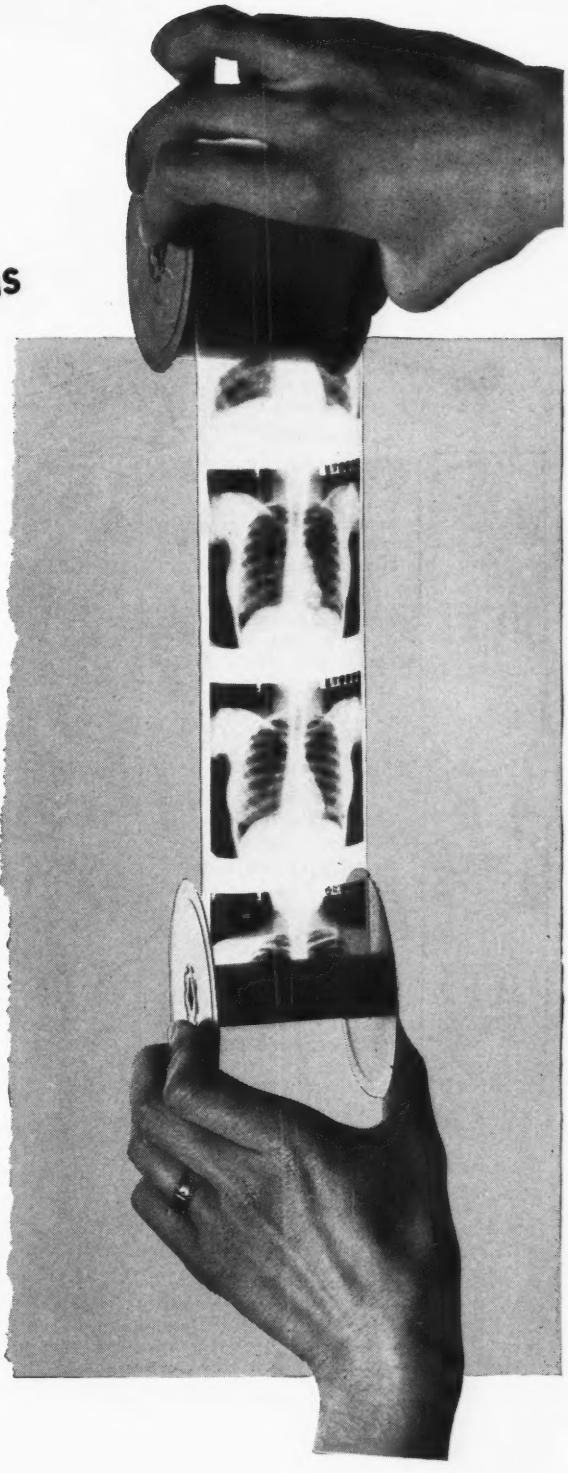

THE CANADIAN HOSPITAL
OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL
JULY, 1946

use this quick, economical method

to screen hospital admissions

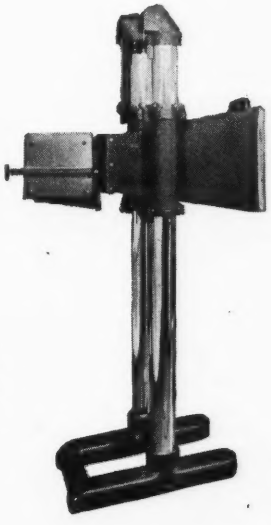


Miniature photofluorography offers hospitals quick, economical help in screening hospital admissions. These routine miniature films enable the radiologist to determine which incoming patients require more thorough chest examinations. Used as a routine hospital admission tool, photofluorography accomplishes three important objectives:

1. Supplies an economical means of determining which admissions require complete chest scrutiny.
2. Recruits patients who might not otherwise receive this examination.
3. Provides accurate telltale signs over and above clinical history and initial physical examinations.

While miniature film methods do not supplant established practices in chest diagnosis, they do perform an important service in augmenting laboratory procedures. Photofluorography need not place heavier loads on the radiological staff. The time needed to read miniatures is minimized, for the chest is either negative or needs standard 14 x 17 radiography for extensive examination.

Write your nearest Ferranti office for complete details on the advantages of miniature photofluorography for hospital admissions.



Westinghouse stationary photofluorograph used in radiographic room and utilizing available generating apparatus.

FERRANTI ELECTRIC LIMITED

X-RAY DIVISION — TORONTO, ONTARIO

CHEST SURVEYS · CANADIAN MADE X-RAY EQUIPMENT

HALIFAX · MONTREAL · LONDON · WINNIPEG · EDMONTON · VANCOUVER

Contents

Vol. 23 **JULY, 1946** No. 7

Canadian Hospital Council

The Federation of Hospital Associations in Canada in co-operation with the Federal and Provincial Governments and the Canadian Medical Association

EDITORIAL OFFICES: 280 BLOOR ST. WEST, TORONTO 5, ONT.

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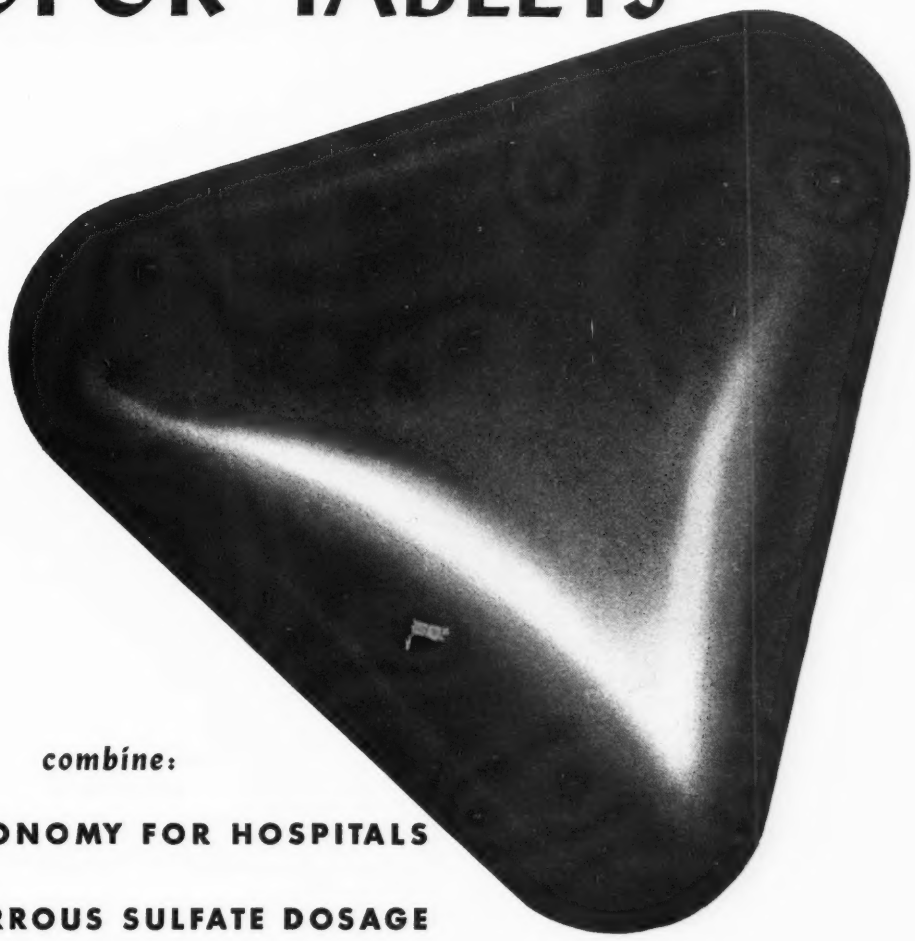
Authorized as Second Class Mail, Post Office Department, Ottawa. The Canadian Hospital is published monthly by The Canadian Hospital Publishing Co., 57 Bloor St. West, Toronto 5.

FESOFOR TABLETS



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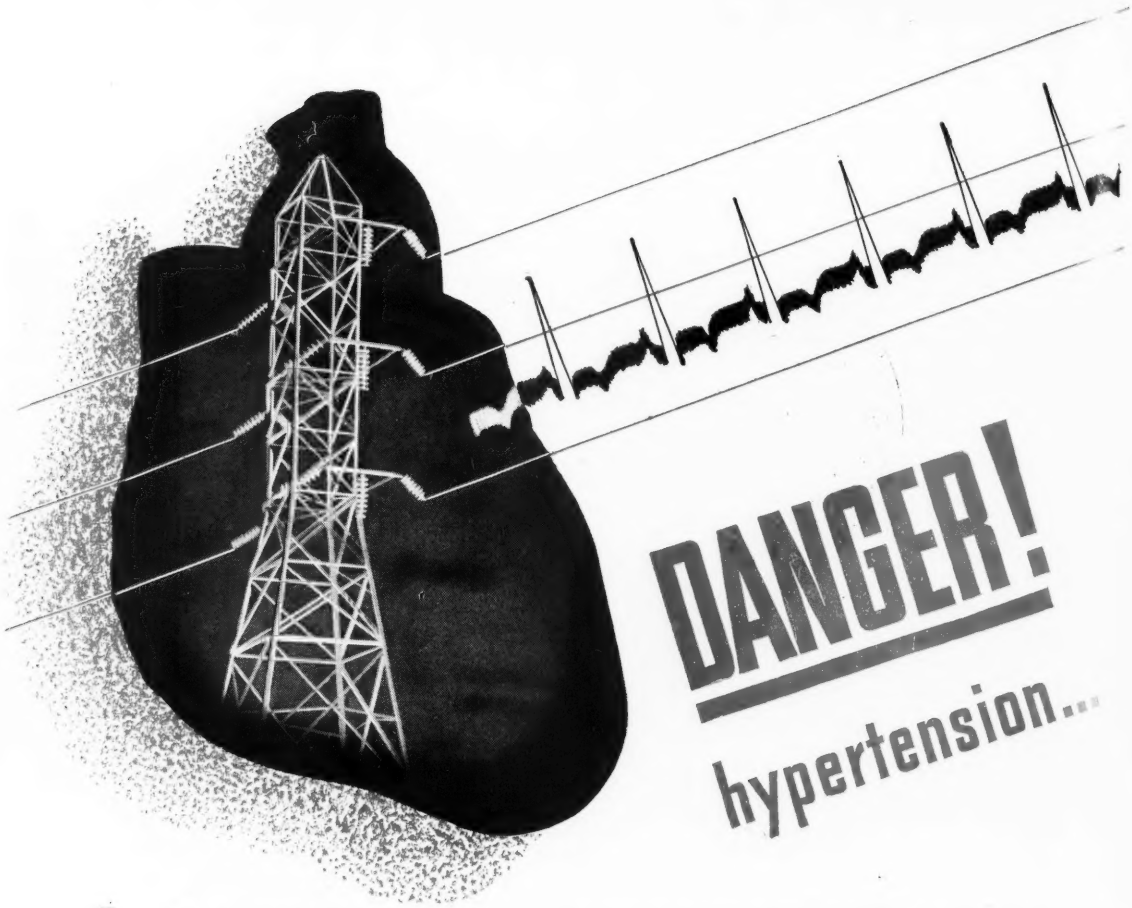

DANGER! hypertension...

Like a high-tension line, the condition of hypertension represents a graver *potential* than actual danger. Anxiety, worry and nervous excitability are the real threats which must be avoided at all costs.

Once the tests have been made, the results checked and the diagnosis confirmed, it is not enough for the doctor to warn his patient to relax and be calm. *Active* measures are needed. In the past many experimental therapies have been attempted in hypertension. Yet to-day the treatment of choice can apparently still be summed up in two words: *Diuretics*, *Sedatives*. 'Tabloid' 'Theoba', combining as it does in one product the *diuretic* action of theobromine and the *sedative* action of phenobarbital supplies a convenient and satisfactory answer to the physician's problem.

Each product contains:

Theobromine gr. 5 (0.324 gm.)

Phenobarbital gr. ½ (0.032 gm.)

Available at all prescription pharmacies in bottles of 100 and 500. Literature will be supplied on request.

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- Cocoanut Creme
- Lemon
- Puff Creme
- Vanilla Creme

for PIES

AT every test, the most discerning dietitians and food experts cannot tell the difference between finished products made from the unprepared materials to those made with Stafford's.

Stafford's use only *genuine* ingredients . . . real egg yolks, whole milk, 100% pure lemon juice . . . and real bean vanilla.

You get the *best* value when you buy Stafford's products . . . laboratory controlled to assure the utmost in perfection and satisfaction . . . made up in a ready-to-use form *for your convenience.*

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ANTISEPSIS

An authoritative statement of the reliability of 'Dettol' in destroying streptococci on the hands

Writing in the British Medical Journal (2.725) the eminent bacteriologist Leonard Colebrook says of ' Dettol ' Antiseptic :

' The most reliable procedure for the complete elimination of streptococci from the naked ' hands is as follows. Wash for one to two minutes in a pint of warm water, using plenty of ' yellow bar soap and a nail brush to the nail sulci ; then pour into the palm of one hand ' a teaspoonful of neat Dettol. . . and work into the skin of the hands till dry (one to two ' minutes).'

When listed, the properties of 'Dettol' read like those of some theoretically ideal germicide. Consider: an antiseptic with a high Hygienic Laboratory coefficient whose bactericidal activity is well maintained in the presence of blood, pus and other organic matter; which is lethal to a great diversity of bacteria, including haemolytic streptococci; which is non-poisonous even at full strength and

MI2A

applicable, without causing injury, to raw wounds and surfaces; which does not inhibit the natural processes of repair; which is stable at all clinically desirable temperatures and at all dilutions; which is non-staining, agreeable in use and pleasant to smell.

Yet that does, in fact, describe 'Dettol' —which in ten years has become the antiseptic of choice, for the protection of patients and staff alike, in nearly every hospital in the British Empire.

'DETTOL' OBSTETRIC CREAM

'Dettol', in the form of a 30 per cent. Cream has been employed as a routine for the hands and vulva in 'hospital cases for the past two-and-a-half years. During this period the incidence of infections due to all 'grades of haemolytic streptococci has undergone a reduction of more than 50 per cent. when compared 'with a similar period immediately prior to the use of 'Dettol', and since there has not been any other 'change in antiseptic procedure, I think the improvement may fairly be ascribed to this factor.'*

* *Colebrook, L. J., Obstet. & Gynaec. of Brit. Emp. Vol. xliii., No. 4, 1936.*

In nearly every maternity hospital in Great Britain and the Empire, the use of 'Dettol,' the modern antiseptic, is supplemented by 'Dettol' Obstetric Cream—a preparation of 30 per cent. 'Dettol' in a suitable vehicle. 'Dettol' Obstetric Cream is ready to use at the right concentration: it can be applied freely to the patient's skin and remaining at the site of application it forms for more than two hours a dependable barrier to re-infection.

'Dettol' Obstetric Cream is used by the doctor and the nurse for the disinfection of the gloved hands; and in the course of long labours for their rapid and effective re-disinfection. For the prevention of self-infection it is smeared over the patient's vulva, thighs and hands—a procedure repeated every two to three hours, particularly with patients suffering from respiratory infections or under the influence of disorientating narcotics.

The records at many great maternity hospitals, such as Queen Charlotte's, London, offer eloquent testimony to the value of these precautions.

RECKITT & COLMAN (CANADA) LIMITED, PHARMACEUTICAL DIVISION, MONTREAL

MI2A

Across the Desk

By C. A. E.

Personnel Required for Arctic Hospitals

THE Hon. Brooke Claxton, minister of National Health and Welfare, would like to hear from doctors who would like to do pioneering work in the outposts of Canada's Eastern Arctic.

Two doctors are urgently needed to head the department's hospitals at Chesterfield, on the north-western shore of Hudson Bay, and at Pangnirtung on Baffin Island. The former is a three-storey, 30-bed hospital with x-ray, surgical and dental equipment. At Pangnirtung the hospital, which is similarly well equipped, has a capacity of 18 beds and is administered along with an industrial home. Each hospital has a staff of two graduate nurses. The men required to take charge should have sufficient experience to handle the surgery of general practice. A house, electric light, fuel and rations to the value of $1,000, freight paid, are provided in addition to a regular salary.

* * * *

D. & G. Sales Promotion and Convention Manager

Mr. Frank M. Rhatigan has been appointed Sales Promotion and Convention Manager for Davis & Geck, Inc. Mr. Rhatigan brings to his new position a unique background, based on his seventeen years in the surgical trade. During this time he has been engaged in convention and sales promotion work for two of the leading manufacturers in the field. A founder of Medical Exhibitors Association, Mr. Rhatigan has served as Secretary, Vice-President, a member of the Board of Directors and now holds the position of President.

Increasing interest in scientific advances places emphasis on the need for increased convention activity for which Mr. Rhatigan is so ably equipped.

* * * *

"Koroseal" Industrial Elastic

Titled "Koroseal, The Modern Flexible Material for Industry", an attractive 18-page booklet has just been published by the B. F. Goodrich Company, Arkon, Ohio and is available from The B. F. Goodrich Rubber Company of Canada, Limited, Kitchener, Ontario. Koroseal is the plastic developed by the company's researchers

(Continued on page 16)

You can *SEE* the quality

of a Johnson & Johnson ready-made

COTTON BALL

DO THIS - Pull a J & J Cotton Ball apart and see for yourself why these machine-made balls are firm, well-shaped . . . why they stay compact.

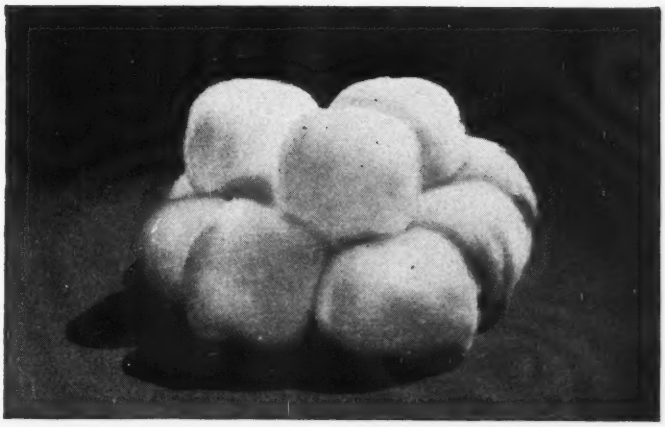
Modern machinery expertly spins the soft, *long-fibred*, surgical-quality cotton into a ball that is uniform in size, shape, weight . . . and is free from nibs. Available in two sizes: *Medium and Large.*

So specify J & J Ready-Made Cotton Balls . . . and avoid the loss of time . . . the cost of labor . . . needed for the old-fashioned, hand-made cotton balls. *An inferior product,* they definitely cost more than machine-made balls . . . *frequently more than the material alone!*

With J & J . . . it's machine-made

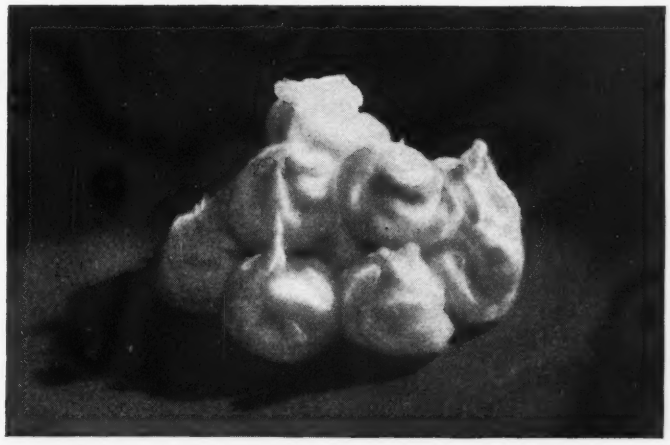
look at THIS...

Here's how J & J Cotton Balls come to you — *all ready for use!* In addition to absolute uniformity, these machine-made cotton balls are economical because of efficient mass-production methods. Yes, even excluding labor costs, they usually cost less than hand-made balls.



then remember THIS...

The inferior, hand-made product. Never uniform . . . with always the tendency to use *more* cotton than necessary. Result: waste and higher costs. Oversized cotton balls also waste solutions in which they are dipped.



AND...don't forget modern J & J COTTON TIPPED APPLICATORS

Neat, uniform and economical, the cotton of these *ready-made* applicators is machine-anchored to ends of smooth, wooden sticks — may be sterilized without affecting anchorage. Quickly absorbent. 100 applicators in cellophane bag; 20 bags in carton. Two lengths — 3″ and 6″.

Johnson & Johnson
LIMITED MONTREAL

.....All the way!

Across The Desk

which made the entire polyvinyl chloride group of chemicals commercially available.

Following a short history of the development, the booklet outlines the material's resistence to destructive elements, including corrosives, oils and solvents, flame, water, moisture, heat and aging, sunlight and oxidation.

Numerous applications of Korseal in all its forms are graphically pictured and described. Of interest to hospitals are Koroseal sheeting, Koroseal coated wallpaper and upholstery fabrics.

* * * *

Sanitary Products Representative

S. H. Goodfellow has joined the sales department of Sanitary Products Company in Toronto, since his discharge from the Army Ordnance Corp. His territory will be all of Ontario and he hopes to personally contact each of the hospitals and institutions in this province. Sanitary Products Co. manufacture a large range of products for hospital use.

* * * *

Oxygen Therapy on Wheels

How can oxygen be best administered to patients during transportation from the operating room back to their beds in other parts of the hospital? This is sometimes desirable in the case of patients who have undergone chest or thyroid surgery. Several hospitals have fabricated simple cradles accommodating a small 80-gallon cylinder of oxygen equipped with a suitable regulator and, if a catheter is used, a humidifier that can be attached easily to the undercarriage of the stretcher. This appears to be a simple and yet effective solution to the problem. The cradles can be fabricated from wood, canvas, or any other suitable material available in the hospital.—*Oxygen Therapy Bulletin of Dominion Oxygen Co. Limited.*

* * * *

Unbreakable Bottle Covering

Glass bottles are being coated with a plastic outer covering which prevents leakage and damage should the bottle be broken. Dipping the bottle in the special solution of nitro-cellulose plastic, a film is formed over the glass so that a second bottle is moulded over the first, reports *Modern Packaging.* A spectacular demonstration shows the strength of the coating. A coated bottle is thrown with great force against the side of a heavy steel

(Concluded on page 20)

added

TO THE MASTER LINE

BOZEMAN'S OBSTETRICAL● AND FOERSTER'S SPONGE FORCEPS●●

We are pleased to announce the addition to our line of Bozeman's Obstetrical Forceps (Uterine Dressing) and Foerster's Sponge Forceps, both in stainless steel with box-lock.

S-230	Bozeman's Serrated	*Straight*	10"
S-231	Bozeman's Serrated	*Curved*	10"
S-220	Foerster's Smooth	*Straight*	9¾"
S-221	Foerster's Smooth	*Curved*	9¾"
S-222	Foerster's Serrated	*Straight*	9¾"
S-223	Foerster's Serrated	*Curved*	9¾"

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OF ULTIMATE PERFECTION

MASTER SURGICAL INSTRUMENT CO.

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Use this handy guide to help you select quality soaps and detergents

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● If you have a problem involving soap, let Colgate-Palmolive-Peet soap experts help you! Their broad practical experience and thorough technical knowledge can help you maintain quality, and in addition save on time, labor and materials. There's no obligation for this service! So get in touch with your local Colgate-Palmolive man or write direct to: Colgate-Palmolive-Peet Company, Ltd., Toronto 8, Ontario.

√ **SPECIAL X SOAP CHIPS** — High-quality soap flakes guaranteed to contain not less than 88% soap. Titer excellent for all flat white work.

√ **SPECIAL X POWDERED SOAP**—A finely pulverized form of Special X Soap Chips, guaranteed to contain not less than 92% soap, 8% or less moisture.

√ **PHOSFOAM**—A ready-to-use soap powder for hot water washing, scientifically blended and dependable. It assures good sudsibility, quicker rinsing, cleaner finished work and lower soap consumption.

√ **GOLDEN XXX SOAP CHIPS**—High quality, huge volume, uniform soap produced from tallow and vegetable oils. A well-balanced soap for all types of laundry work. Guaranteed 88% real soap, 12% or less moisture.

√ **GOLDEN XXX POWDERED SOAP** — 92% pure soap, 8% or less moisture.

√ **COLGATE KWIKSOLV**—A granulated 92% anhydrous soap. Titer 20°F. for so-called "cold water washing" of fine fabrics.

Please accept our apology for short supply. We hope that freer supplies of raw materials will soon enable us to serve all customers adequately.

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Across The Desk

office safe. Although the glass inside is shattered by the force of the impact, the plastic "bottle" remains undamaged, and not a drop of the liquid contents is lost. Most liquids would be held long enough to permit discovery of breakage and transfer of contents. The coating can be dyed to provide quick identification of contents.

* * * *

Price of Groceries Sold to Hospitals

On sales to restaurants, hospitals and institutions buying in quantity, some grocery wholesalers have been charging a markup on cost greater than is allowed by the product order or other Wartime Prices and Trade Board authorization which covers the item. This practice is illegal.

On items with ceiling prices regulated solely by what was charged in the basic period, a wholesaler must not charge any class of customer more than he charged the same class of customer in the basic period. This is regardless of the fact that he may hold both a wholesale and a retail license from the Board.

* * * *

C. Carroll Adams' New Appointment

Davis & Geck, Inc. has announced the recent election of C. Carroll Adams as vice-president of the company. Although having served as assistant general manager since 1941, he is best known for his contributions to advertising and visual education in the surgical field. Joining the company in 1924, after serving in the Army Medical Corp during World War I, he directed the professional service and special products section of the company. He was appointed advertising manager in 1926 and being imbued with the idea that doctors were after all human beings, pioneered the use of dramatic illustration in medical advertising. This work received a number of awards from advertising and art groups, and the series on surgical history was recently published in book form by Hastings House.

With the conviction of the practical value of visual education as a medium of teaching medicine and surgery, he developed the D & G Surgical Film Library, which through the preparation and distribution of films dealing with surgical subjects has become an institution in its own right.

* * * *

Glass Fillings for Your Teeth

An enterprising dentist has discovered that he can fill the root canals of dead teeth with glass and obtain a more permanent and durable job than with the usual gutta-percha or other filling materials.

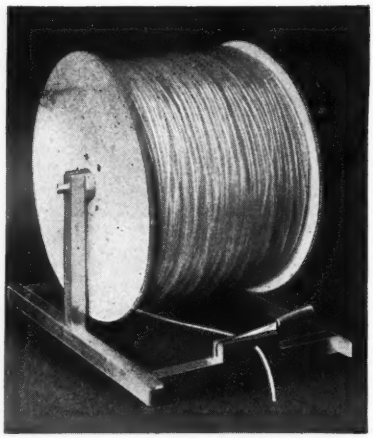
Using a flexible glass thread about 18 inches long, he packs the root canal solidly, making a homogeneous filling that is more solid than rubber. It is also completely nontoxic, will not irritate its surroundings or change chemically; it does not absorb moisture. Thus a glass-filled dead tooth is likely to serve considerably longer without risk of infection.

A special experimental glass is used that is opaque to X-rays. When the root canals are very small or have numerous branches difficult to fill, photographs can be taken at various stages of the operation to make sure that no spaces are left.—*Cosmopolitan Magazine.*

Fenwal CONSOLIDATES THE TUBE AND NEEDLE SET

Practical innovations exclusively featured in Fenwal Tube and Needle Sets now overcome the most difficult and time-consuming factors in parenteral therapy procedure.

- **INSURES CONSISTENTLY CLEAN TUBING.**
- **REDUCES CLEANING TIME.**
- **FACILITATES SIMPLIFIED ADMINISTRATION.**
- **REDUCES POTENTIAL BREAKAGE LOSS.**



REEL STAND WITH CUTTER

Fenwal Sets provide single vent tubes and expendable tubing. Here are the facts.

REEL STAND WITH CUTTER

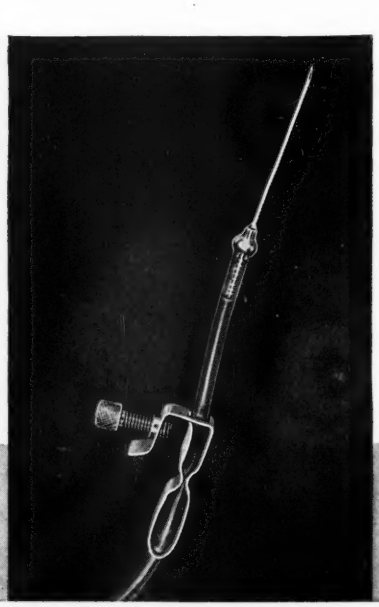
This sturdily constructed, chrome plated, metallic Reel Stand is designed to accommodate a 12" reel of Fenwal expendable tubing of 3000 foot length. Cutter attachment permits instant preparation of lengths as required.

AIR VENT TUBE WITH INTEGRAL DRIP

Scientifically designed to require only one connection instead of three. Saves cleaning time as there is only one tube to clean instead of two. Apparent economy because of lower breakage potential.

FLOW-CONTROL CLAMP

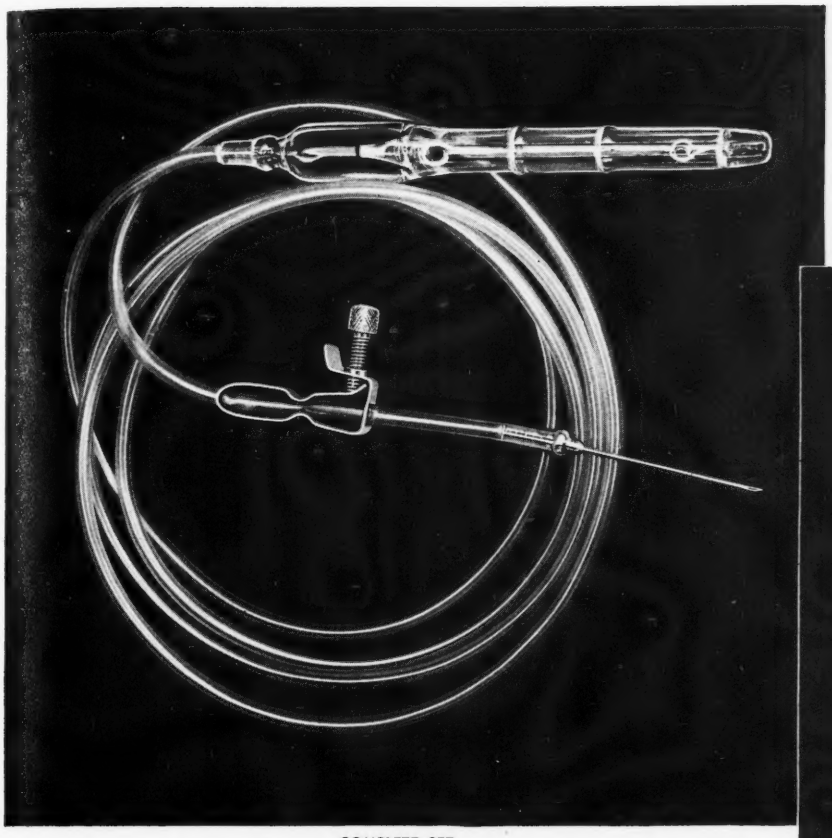
This unique Fenwal Clamp provides for instant control of any desired fixed-drip range of flow. A snap-lock design facilitates instant and total shut-off and resumption of flow. An adjustable screw serves to control desired rate of expressage. This rustproof, lightweight Clamp cannot become accidentally detached from tubing thus providing an additional safety measure of importance.



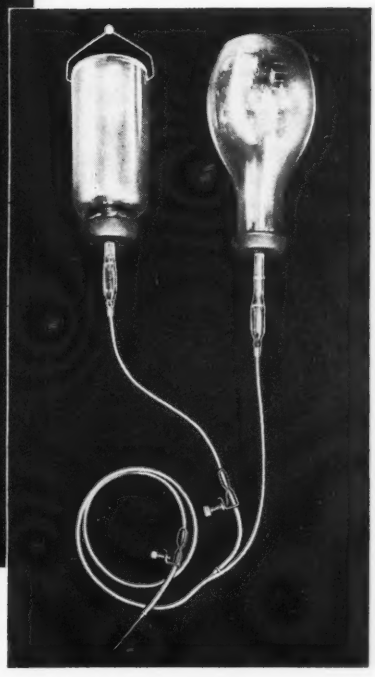
SECTION OF CLAMP AND NEEDLE

EXPENDABLE TUBING

Fabricated of transparent plastic, this expendable tubing may be sterilized once in conjunction with needles, collecting tubes and dispensing filter tubes . . . and discarded. Eliminates tedious cleaning of tubing. Eliminates potential hazard of reusing tubing not thoroughly cleansed. Conserves distilled water supply.



COMPLETE SET



USE OF SUPPLEMENTARY MEDICATION

Illustrating simplicity and time-saving convenience of administering supplementary medication by puncturing of expendable tubing.

FENWAL NEEDLES

Especially designed with solid, tapered distal end through which the lumen is extended to a flush surface. Offers greater safety as there is not recessed area to make cleaning difficult. Unexcelled for use with Fenwal expendable tubing.

ADAPTER (for standard needles)

Made of Pyrex Brand glass with precision ground Luer tip, this adapter provides a ready means of using Fenwal expendable tubing with standard needles.

TUBING ADAPTER

Designed to facilitate the use of Fenwal expendable tubing in conjunction with commercially prepared solution containers and non-Fenwal tube and needle sets.

SPECIFY CATALOG NUMBER WHEN ORDERING	
Item	*Catalog No.*
FENWAL Plastic Tubing Reel of 3000 feet	W9037
FENWAL Reel Stand with Cutter	W9038
FENWAL Single Vent Tube with Drip (Cs. of 48)	W9016
FENWAL Special Needle (Bx. of 12)	W9056
FENWAL Flow-Control Clamp (Cs. of 48)	W9054
FENWAL Adapters (Cs. of 48)	W9031

PIONEERING THAT POINTS TO *DISCOVERY* . . . *DISCOVERY* THAT *DEMANDS* LEADERSHIP

Baxter

PIONEERS IN PARENTERAL THERAPY

Marcello Malpighi

1628-1694

In 1661 Marcello Malpighi discovered the blood capillaries. One of the greatest microscopists of all time, Malpighi made his discovery with the crude Galileo instrument and without benefit of staining techniques. Thus accurate knowledge of the circulation, begun by Harvey, was completed and another link forged in the chain which led to present-day parenteral therapy.

Another *Baxter* Pioneering Achievement . . . the Vacoliter

Another milestone in the development of parenteral therapy occurred in 1931 when Baxter presented to hospitals and the medical profession the first vacuum container for intravenous solutions — the Vacoliter. The Vacoliter container-dispenser makes possible Baxter's safe, simple, aseptic technique of intravenous infusion—the first permanent safeguard of solution sterility.

Baxter's many years of pioneering and leadership in the field of parenteral therapy are your protection. Here is a parenteral program complete, trouble-free and confidence-inspiring. No other method is used in so many hospitals.

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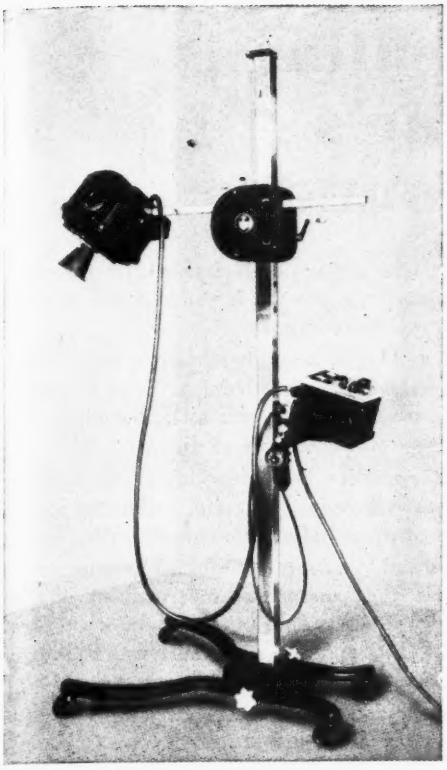

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Obtainable in two styles . . . table-type tubestand or mobile tubestand illustrated. Both provide many advantages of more expensive, full scale equipment. Complete range of positions, vertically and horizontally for radiography or fluoroscopy. Both tubestand give complete flexibility for the office or hospital . . . diagnosis can be confirmed right in the office or at the patient's bedside.

K-30 DE LUXE VERTICAL FLUOROSCOPE ▶

Design improvements such as elimination of the protruding carriage arm make savings of one third in floor space. The screen is universally adjustable, giving unusual freedom of movement. The Patterson High Intensity Type B Screen is 12″ x 16″ and has 14″ transverse travel, and accommodates the Keleket Outhodiagraphic attachment. Floor space required is 40″ x 48″. Height of cabinet, 76″.

C O N V E N T I O N

Meeting of the Canadian Society of Radiological Technicians at the General Brock Hotel, Niagara Falls, Ont., Sept. 26-27-28.

X-56

Illustrated descriptive literature sent on request. Address correspondence to

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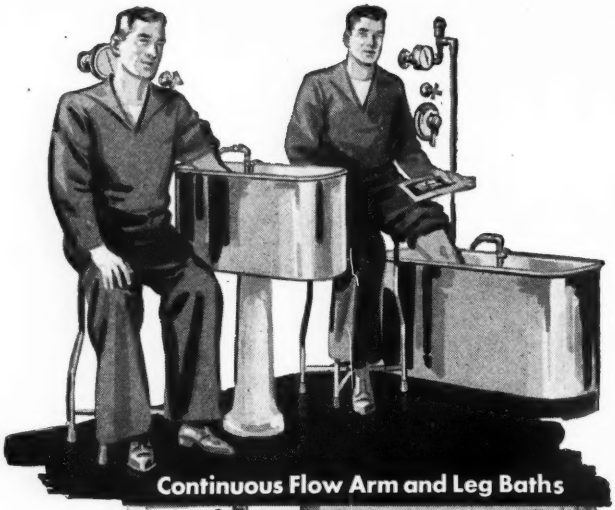
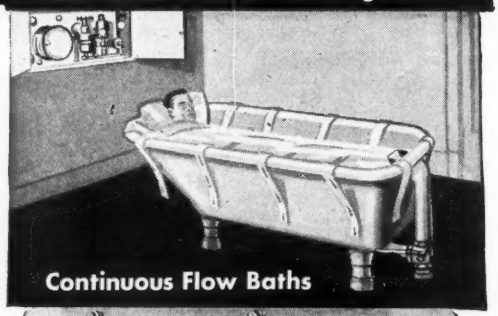


Continuous Flow Arm and Leg Baths



Continuous Flow Baths

Hand and Foot Contrast Baths

Healing War's Wounds

For maladies of war—both physical and mental—hydrotherapy is proving a valuable aid in promoting rapid recovery.

Arm and leg baths aid in advancing recovery in peripheral nerve injuries, indolent ulcers, adherent scars, osteomyelitis of terminal phalanges and fractures after the removal of the cast.

Continuous flow baths provide a gentle massage and are recommended by many authorities in the treatment of mental and nervous disorders.

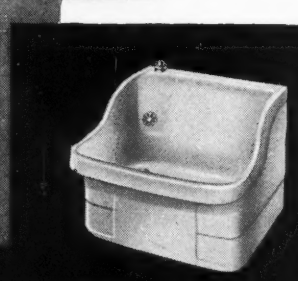
Hand and foot contract baths are used by many hospitals and sanatoriums in treatment of circulatory diseases and other conditions where alternate heat and cold are indicated to stimulate circulation.

Hydrotherapeutic showers are of value in providing a rain douche or needle spray shower, supplying a stimulating massage in nerve cases, or a shock treatment in mental cases.

The complete Crane line of hospital plumbing includes every item necessary for the hydrotherapeutic department. Because of the value of hydrotherapeutic treatment in war casualties and in the promoting of civilian health, you may be considering installing such a department or expanding your present one. If so, consult your plumbing contractor or the nearest Crane Branch for complete information.

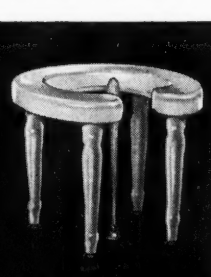
CRANE LIMITED: HEAD OFFICE:
1170 BEAVER HALL SQUARE, MONTREAL

Rain Douche and Needle Spray Shower



Sitz Baths—using cold, neutral and hot water—offer a wide range of hydrotherapeutic applications.

Foot-Soak Baths are recommended for conditions requiring long immersion in hot or cold water or antiseptic solutions.



The Perineal Douche delivers solid stream or spray. It is of value in treatment of the pelvic organs.

CRANE VALVES • FITTINGS • PIPE
PLUMBING • HEATING • PUMPS

NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS and PLUMBING AND HEATING CONTRACTORS

Harvey Agnew, M.D., Editor

Toronto, July, 1946 Vol. 23 The CANADIAN HOSPITAL No. 7

Environmental Sanitation

----*As Applied to Hospitals*

Part 1

ENVIRONMENTAL sanitation simply means the control of conditions which might lead to the spread of communicable disease and the control of conditions which might cause nuisances. Since the public believes that the local hospital maintains the best conditions for the care of the sick, it follows that the public looks to the hospital as a leader in environmental sanitation and the prevention of disease.

Water Supply

The hospital water supply should be safe and potable. By "safe" is meant that the bacteriological quality of the water should be well within recognized standards, which require that the number of sewage bacteria in the water be sufficiently low so that the water cannot be a factor in the spread of disease, and that the water contain no harmful chemicals or impurities. It is suggested that a regular water sampling program be adopted by every hospital.

Some smaller hospitals have a private source of water supply, usually a well. To ensure safety, a well must be located sufficiently far away from any source of contamination—such as a septic tank, privy or stable—as to ensure that the ground water will not be contaminated in the vicinity of the well. The well should then be so constructed that it is impossible for surface drainage to enter the sides or top. This can be accomplished by cribbing the well with water-tight concrete and providing it with a water-tight cover. Where the pump stem passes through the top of the well, there should be provided a water-tight gasket. This will prevent splash water from returning to the well and will also prevent oil and gasoline used for the pump engine from entering the well.

Water samples should be taken regularly from taps in the hospital because there may be cross-connections in the hospital system. Or there may be possibilities of back siphonage occurring in plumbing fixtures, especially in certain types of hospital sterilizers. Any plumbing fixture or sterilizer in which the clean water enters the fixture below the overflow surface of water that can be contained in the fixture, is dangerous. Another reason for regular water samples by the hospital is to make sure that the water from the source is pure.

If the water is found to be unsafe, the source of the water should be studied very carefully in order to see whether or not the contamination can be eliminated at the source. If not the water should be either boiled or *chlorinated.* If the water comes from a surface source such as a stream or a lake, chlorination is always advisable. There are small chlorination machines on the market which can be obtained at a reasonably low cost. For chlorinating water in a vessel a solution containing 2

R. BOWERING, B.Sc., M.A.Sc.,
Public Health Engineer,
British Columbia Board of Health

From an address at the Pre-Convention Instructional Course, B.C.H.A., Vancouver, November, 1945.

per cent available chlorine can be made by adding three ounces of fresh chloride of lime to one quart of water. The water and lime are mixed by placing the chloride of lime in the bottom of a vessel, adding the water slowly and stirring until a good paste is formed. Then sufficient water is added to make up to one quart. One or two drops of this solution added to a gallon of water with a medicine dropper will sterilize the water without causing a chlorine taste. If the water is turbid or cloudy, more chlorine solution should be added.

Also there should be sufficient water available for *fire protection.* If the public water supply has not the capacity for good fire protection service, an elevated tank may be used as a water reservoir. The Fire Underwriters' Association are always willing to give advice on the best means of fire protection.

Another feature relating to water supply is the *ice supply.* Ice, if made on the premises, should be made only of safe water. If the ice is purchased, the hospital authorities should see to it that it comes from an approved source. It should be handled in a sanitary manner at all times. Chipped ice used in drinking water should be handled with small tongs rather than by the hands.

Sewage Disposal

Where a hospital is located in a district in which there is a public sewerage system, the hospital authorities have little to worry about regarding sewage disposal. However, many of our smaller hospitals are located in districts where no such facilities are available. In these cases, the best type of sewage disposal plant to use is some form of septic tank, with an absorption bed for the disposal of the effluent. This is not a hard and fast rule, and wherever a hospital has a sewage disposal problem it is best for the manager to write to the Provincial Board of Health for advice. Briefly, a septic tank is a device in which a proportion of the solids from sewage are retained and digested by anaerobic bacteria. The effluent from the septic tank still contains a proportion of the sewage solids and a good proportion of the sewage bacteria. For this reason septic tank effluent, unless properly disposed of, is dangerous. Usually the best method of disposing of it is by the use of an absorption bed. This is simply a set of agricultural tiles properly laid out in the soil.

Plumbing

The plumbing in a hospital should be properly designed and maintained. If it has not been put in by a qualified plumber, or if it is known that the system was not inspected when it was first installed, it would be wise for the hospital to have a thorough inspection made. The Provincial Board of Health stands ready to assist hospitals by making such inspections.

Refuse Disposal

Covered metal containers should be used for the collection of garbage in a hospital. The garbage should be emptied from these containers at least once a day. The garbage should then be disposed of in a safe manner —incineration is the best method. If there are no means for proper incineration, it should be buried so that it does not become a breeding place for flies or a feeding place for rats and other rodents.

All garbage from communicable disease patients should be burned. Garbage cans should be washed thoroughly with hot water and soap and sterilized with steam or hot water once a week. Very often the reason why a garbage can smells sour is not because it is not emptied often enough but because there is stale organic material adhering to the lining of the can.

Rodent Control

If the hospital is located in an area which is infested with rats, a rodent control program should be carried out. The prevention of any accumulations of garbage will assist greatly in keeping down the number of rats. Since their numbers are usually proportional to the amount of garbage and other food supplies available, all such supplies should be stored in such a way that they will be inaccessible to rats, and the building itself should be made rat-proof. Information on this procedure may be obtained from the Board of Health. In addition, if there are any rats around the premises the proper use of traps and poison bait will help to control the infestation. In short, in order to control rats: build them out, starve them out, and use traps and poison if they should gain access to the hospital premises.

Control of Flies and Insects

It is well known that flies are carriers of disease germs. Around a hospital, particularly if there are any cases of communicable diseases present, the control of flies is of paramount importance. It is possible that many of the so-called "cross-infections" in a hospital are caused by flies.

One of the first essentials in the control of flies is the proper collection and disposal of the garbage in which they breed and feed. Secondly, ingress of flies into buildings should be prevented by the proper use of screens. Thirdly, proper ventilation of rooms will tend to discourage flies from entering a room. Stale odours, or odours from cooking, attract flies, and good ventilation tends to prevent odours. Fourthly, proper methods of eradication of flies should be used. Some of the new DDT preparations will be found valuable for control of flies and other insects which infest hospitals, such as bedbugs and cockroaches. The best specific insecticide to use in the control of cockroaches is sodium fluoride.

(Part II on "Food Handling" will appear in our August issue).

McGill Announces Course in Nursing Supervision

A new post-graduate course in Supervision in Obstetrical Nursing has been established in McGill University, the first class to open on September 3rd of this year.

Applicants must have at least six months of successful obstetrical nursing, and have shown their adaptability to this field. The course will be a full university year, and will include lectures and related clinical experience, conferences, demonstrations and special studies. The purpose is to prepare obstetrical nursing supervisors who will be qualified to administer and supervise the nursing service as well as to develop clinical educational programs.

Application forms and further information may be secured from the Director, School for Graduate Nurses, McGill University.

Architect's sketch of Youville Hospital as it will appear when construction of the new wings is completed. Capacity 200 beds.

Extension of

Youville Hospital

THE first hospital in the vicinity of Rouyn-Noranda, Quebec, was opened by the Grey Nuns of the Cross from Ottawa in October 1925. A large house was converted into a thirty-bed hospital at that time and for four years it provided hospital service to the pioneer population.

In 1929, at the request of the authorities of Noranda Mines, the Nuns built a new hospital situated between the twin towns. This was a four storey building containing 80 beds, and for seventeen years its doors have been open to injured miners, settlers from the surrounding district and all outside patients who needed care. Unfortunately it soon became clear that the hospital was too small for the growing population. By 1945 the number of patients admitted had risen to 4,319, of which 2,097 were surgical cases and 516 maternity.

Plans to extend the hospital were prepared about ten years ago but the outbreak of war made it necessary to postpone construction. Then in March of this year the contract was let and work on the new wings was started. The capacity of the hospital will be increased to 200 beds at a cost of half a million dollars.

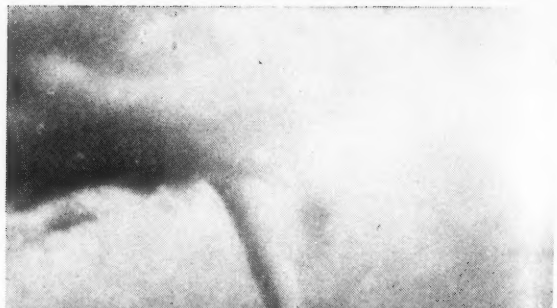
The new sections will be of brick conforming to the present building, with steel framework and concrete floors covered with tile or linoleum. The main entrance will be moved from its present location to the new 50′ by 50′ central portion with curved outer wall. In addition to the entrance hall, there will be an information bureau, administrative offices and a doctors' room in this space. The hospital will have four modern operating rooms and the most up-to-date sterilizing and utility equipment. X-ray facilities will be enlarged and improved. When completed, about a year hence, Youville Hospital will be the chief medical centre in western Quebec. The architect is Mr. Auguste Martineau of Ottawa.

The Sisters appreciate very much the co-operation of the highly qualified medical staff and they are also grateful to all those who encouraged them in this enterprise, especially the Provincial authorities, officials of the Noranda Mines and of the surrounding mines.—*S.G.C.*

Left: Present Youville Hospital. Capacity 80 beds. Opened in 1929. This building will become the left wing of the new structure shown above.

Above: Original hospital, opened in Rouyn in 1925. Capacity 30 beds. Today it is a boarding school.

The Windsor Tornado



THE freak tornado which swept suburban Windsor on the evening of June 17th destroyed homes over an area of twenty-five square miles, brought death to sixteen persons and injury to scores more. The task of the hospitals which had to cope with this sudden disaster was complicated by the fact that the storm snapped two high tension towers which served the city with hydro power, plunging most of the community into darkness. Telephone service was disrupted and gas mains were turned off for fear of fire.

In the words of Mr. Horace Atkin, superintendent of the Metropolitan Hospital:

"Just before six o'clock rain began to fall, accompanied by hail. At six o'clock, to the west of the city, the tornado, a twisting cone, moved rapidly across the Detroit river and struck at the Township of Sandwich West, laying waste homes and bringing death and suffering to whole families. It veered eastward, striking down everything which stood in its path as it moved in the Township of Sandwich East, finally to dissipate itself to the east of the city. In its wake thunder and lightning rolled, and rain continued to fall through the night."

The hospitals were immediately on the alert to receive the expected casualties. Luckily the disaster occurred just at the change-over from day to evening staffs, so that extra personnel were available.

Power Shutdown

The most pressing need was for light. Apparently Grace Hospital was the only one possessing an emergency lighting system. According to Major Doris Barr, Superintendent of Nurses: "The system furnishes light for delivery rooms, laboratory (there is even a small bulb on the microscope), corridors and office. These lights are all fixed to throw a broad beam ahead and are useful in illuminating the corridors, giving patients sufficient light to keep them from getting into a panic." However, the system proved inadequate for the tremendous demands made upon it, so "an immediate appeal was made to the Fire Department. Within minutes firemen had installed their mobile lighting unit outside, run insulated cables through an open doorway and installed high-power flood lights in all operating rooms. This work was completed almost as soon as the first ambulance arrived."

What would happen in your hospital if suddenly ambulances and private cars began bringing injured persons by the dozen to your door for attention? And what if this situation were complicated by a power failure?

At the Metropolitan, Mr. Atkin relates: "We had a few emergency lights, flash lights and operating room lights left over from A.R.P. days. They proved invaluable but hopelessly inadequate. There was no emergency lighting system in the hospital, and nurses and staff were dependent upon candles and electric torches . . . Within a few minutes of the arrival of the first car of injured, neighbours and residents in the vicinity of the hospital came forward with flash lights, lamps, lanterns and everything of use from their homes . . . Industry also provided all available lighting equipment . . . The power break had stilled the blowers which increase the furnace fire, and our engineers were in desperate straits endeavouring to keep up steam pressure for sterilizing and cooking. By eleven o'clock steam pressure was so low it was impossible to make coffee."

Hotel Dieu had the most difficult

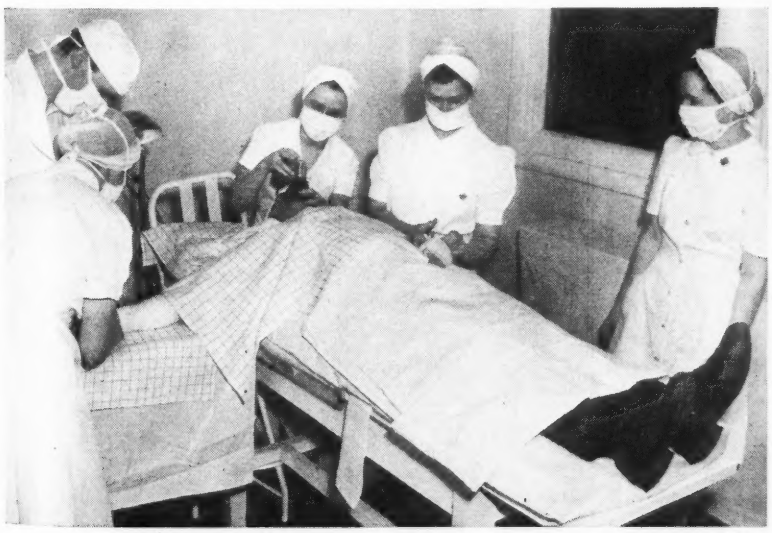
time of all. Mother Claire Maitre recounts: "As soon as the storm started our chief engineer rushed back on duty and, on learning that hydro lines had been badly crippled, got in touch with me to report the additional disaster of the engine rooms filling with water, due to shutdown of our electrically-operated pumps, and to ask for authority to procure pumps, batteries, etc. I told him to act first and report later, as long as he could provide us with light and steam as soon as possible. By eight o'clock large flash lights, gasoline and oil lamps were lighting up the halls, stairs and operating rooms. By about nine-thirty battery sets were operating at the ambulance entrance, operating room and obstetrical departments, and by ten o'clock generators, rushed over from Detroit in answer to the Mayor's appeal, were supplying 50 per cent light to the whole building, although elevators could not be operated. Meanwhile our maintenance men and orderlies took turns bailing water from the vital power centres until pumps arrived, and the assistant engineers fed the furnaces by hand. In this way enough steam was procured to carry on obstetrical deliveries and emergencies and to serve hot meals all day Tuesday."

Care of the Injured

Medical staffs, nurses, orderlies, etc., were on hand in more than sufficient numbers to handle the casualties admitted. All nurses and doctors reported back for duty at once. The nursing staff of the City Board of Health reported to the Metropolitan and stayed with the injured throughout the night. Mother Maitre reports of Hotel Dieu: "A call sent to the nurses' registry brought graduates who were kept on to give special care to the critically injured. Only the students needed were kept on, while the remainder were sent back . . . We felt that our badly-frightened patients would need the tactful care of 'rested nurses' following such a harrowing night, for the storm raged on unabated almost until morning."

The lack of elevator service imposed a severe handicap in transporting the more seriously injured victims. Teams made up of hospital employees and civilian volunteers were organized to take stretcher cases to the operating rooms. In the case of the Metropolitan this meant carrying them up four floors, and thirty-three patients were so transported! At Grace Hospital, according to Major Barr: "Four operating rooms did double duty—one patient receiving treatment on a stretcher, the other on the table, thus enabling us to handle eight cases at a time."

The less critically-injured were cared for in emergency rooms and later dispatched to their homes or to the Y.W. and Y.M.C.A., which served as clearing stations for discharged cases, as well as for all relatives and friends left homeless by the tornado.



A fracture case is attended to in the emergency room of the Metropolitan. Note that the patient is fully clothed.

Other Services

Grace Hospital found the shutdown of laundry services one of its most vexing problems. "We overcame this obstacle by using fresh linen for making up empty beds and for emergency use only, thus conserving our diminishing resources. And, of course, since all operations for the next day had been cancelled (a procedure which all hospitals adopted), we were left with a small surplus."

The dietary departments performed impossible feats under impossible conditions. Mr. Atkin reports: "With so many volunteer workers giving of their time and effort to the easing of a tremendous task, the dietary departments was called upon to serve coffee and sandwiches to hundreds of helpers who had gone without meals to speed rescue work."

A vital part was played by admitting and information departments in keeping accurate records during the confusion of a mass entry of patients and with only flash lights or stable-type lanterns to work by, in supplying information to distraught friends and relatives and in assisting newspapers as much as possible under the circumstances.

Recommendations

Mr. Atkin feels that certain conclusions can be drawn from this terrible community experience:

"The emergency lighting system, no matter how small, is an essential for a modern hospital. If it had not been for the co-operation of the various fire departments and the great demonstration of goodwill by American agencies, the hospitals of Windsor would have faced an impossible situation.

"I am also convinced that circular ramps would be an asset to any hospital. These runways could be constructed to provide easy transit of stretcher patients. There is nothing which renders a hospital more helpless than the failure of power, bringing with it a stoppage of its elevator service.

"Another thing which stood out was the advantage of a competent operator on the switchboard, which becomes the nerve centre of the entire organization in an emergency. The operator must be efficient, have initiative, a calm disposition and a

(Concluded on page 76)

Post-War Trends in

Convalescence

SARA P. TANSEY,
Superintendent, Montreal Convalescent Hospital

THE convalescent patient has been confused in so many minds with the chronically ill or long-term patient that it is encouraging to find the distinction at last being more clearly understood. In truth, however, there is a period in convalescence in which certain patients make a transfer from one stage or type to the other; thus fracture patients, sometimes fairly long-term ones, are considered as a rule as definitely convalescent, while those with rheumatic ills or heart ailments all too frequently turn out to be more or less chronically ill patients.

Naturally the classifications of chronic and convalescent care will be more generally agreed upon when facilities for the chronically ill become more widely available.

Prior to this happy day the convalescent hospital, doing a community job, is more or less required by the urgent need to accept patients beyond the exact definition of the term. Education of doctors in this respect is vitally important.

Convalescence is the bridge between acute hospitalization and the return to normal living. It should be a pleasant, relaxed period in which the patient is not hampered by many restrictions; in which medical attention, while available, is not constant nor all-pervading and in which discussion of symptoms is not overly encouraged.

The psychology of convalescence, broadly stated, is that the worst is over, pains and aches will soon be a thing of the past and from this point on revival of interest in social activities is essential. If the patient has no absorbing outside interest there is a lethargy of spirit that retards convalescence.

Many convalescent homes restrict themselves to ambulatory patients for whom games and other exercises are prescribed; in our institution the average number of patients receiving bed care runs around 50 per cent. However, the timely placement of chronic cases would lower this average.

While the duplication of active hospital services must be guarded against, there is an irreducible minimum of expense required to achieve smooth functioning in this type of institution. Good food, correct diets and efficient nursing care are comparable with acute hospital expenditure in these lines, with possibly slightly higher food costs as nutrition is one of the prime essentials of convalescence.

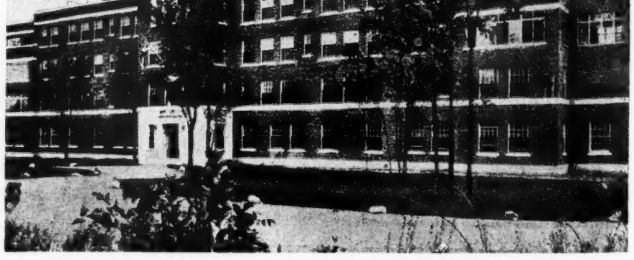
The basis of operation must be co-operation with referring hospitals, continuity of treatment being the essence of value in this branch of hospitalization (provided, of course, that there is that affiliation with other hospitals which is generally recommended as good convalescent practice).

Use of Therapies

The desirability of using therapies is generally recognized but there is room for discussion of the extent to which they should be used and their relative values.

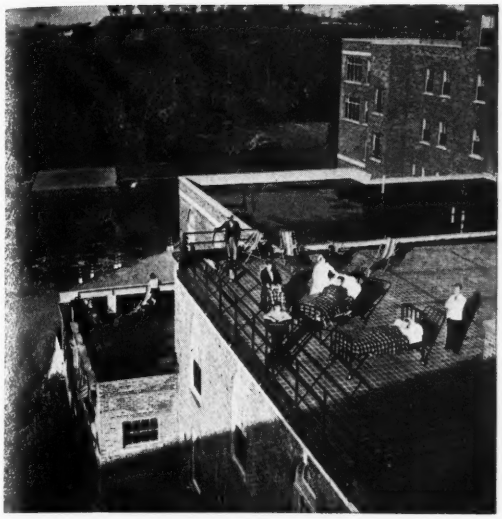
Physical therapy, in our opinion, should not necessarily imply expensive or rather extensive equipment in convalescent hospitals as long as referring hospitals, well equipped in this respect, are easy of access.

Occupational therapy has a definite value though it is difficult to achieve in short-term true convalescence. The days of such patients are filled with trips to clinics, generous visiting hours, rest periods, social tea gatherings, celebration of feasts and festivals, movies and concerts, knitting parties, outings on the terraces or walking about the grounds. There may be disagreement with this statement but in actual practice we have found it difficult to arouse enthusiasm, for this department, especially among walking patients. Perhaps the years of war, hard work and mental strain,



Front View, Montreal Convalescent Hospital.

An address given at the Montreal Regional Conference of the American College of Surgeons in March, 1946.



Sun Terrace

have predisposed patients for rest as against competitive activities.

Of course the rehabilitation of soldiers is a different proposition. Making the combatant fit to return to combat as early as possible has necessitated and explained graded exercises and activities, but for civilian life the curative properties of rest in an easy friendly atmosphere, with no rigid routine, has much to commend it.

We dwell upon this point because with the necessary speeding up of treatment in acute hospitals in the present day, we have had it brought to our attention by many patients who complain of tiredness after hospitalization.

Lower per diem rates is one of the telling arguments for the establishment of convalescent institutions and here we wonder if ideally equipped convalescent hospitals, with thoroughly adequate and diversified physical and psycho-therapy departments, may not step out of their class and become specialized institutions.

To SUM UP briefly:

Ideally—and we should strive to attain the ideal—the four cardinal principles of convalescence on which adequate convalescent care depend might be termed:

1. Rest,
2. Nutrition,
3. Physical Therapy,
4. Psycho-therapy.

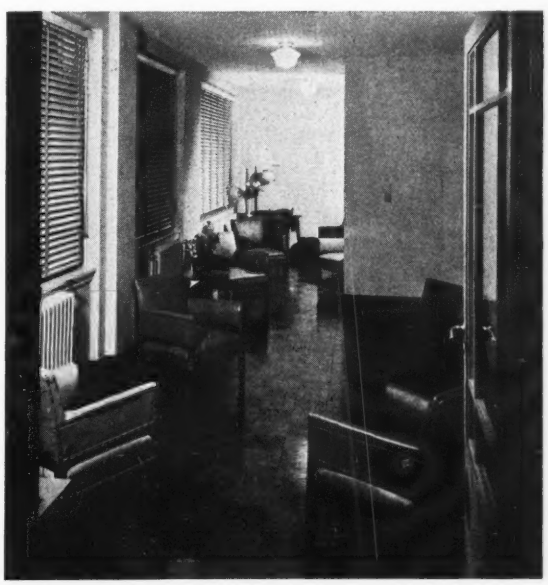
As regards *Rest,* it has recently become the fashion to decry its usefulness; it is well, therefore, to remember that it still constitutes the first and most necessary factor in promoting recovery from illness. Of course, getting the most from rest implies not over-doing it.

Nutrition: Provide the optimum in nutrition by a high caloric, high protein and high vitamin diet, presented in an attractive and palatable form.

Physical Therapy: Those acquainted with the recorded experience of the Medical Corps of the Allied Armies in the recent War cannot doubt the need for this form of treatment in order to ensure full recovery in the shortest possible time. As in the Armed Services, though of course not to the same extent, a large number of civilians are the victims of trauma and require remedial treatment with various types of therapies. These should be studied carefully with a view to their real value to the individual patient.

Occupational and Psychotherapy: Occupational therapy should not be limited to the fashioning of pretty but purely decorative objects. To be most effective, the articles produced should have as high a utility value as possible. Organized recreation should include movies, stage productions and games varied to suit all tastes. For those who will have to change their way of living because of the new demands of their health, some educational program should be provided. This program should make clear to them the possibilities and limitations of their future level of health.

So much for the ideal. Practically speaking, unless the cost of the ideal program can be underwritten somehow by special grants or gifts, convalescent care must struggle along on a utilitarian rather than an ideal basis. However, whether operated on an idealistic or on a practicable standard, there must be established as a priceless ingredient of its service a friendly personal contact and kindly relations with all patients.



Sun Porch

Come Up and See Us Sometime!

The New Council Offices Are Inviting

By Charles A. Edwards

IN an illustrated feature in a recent issue of *The Saturday Evening Post,* the author-artist poked fun at the exaggerated claims made by real estate agents in their advertisements describing property for sale and for rent. One example: "*Beautiful View of River.* (At times when the river misbehaves it may even be seen in the living room, with the end tables floating around)".

If the landlords of our new Council offices at 280 Bloor St. West, had, a few months ago, advertised these premises as having "*Unique and Interesting Layout*", President Swanson and Secretary Agnew would have at least been rather dismayed when they had their first peek at these rooms. As in almost any large old residence in central Toronto, the "third floor rear" presented a futuristic vista of angles. Add to this a staircase one had to walk around, blind alley cubby holes and dormer windows seen through a maze of unhinged doors, large sections of Masonite board, falling plaster, paint pails and piles of sawdust and odds and ends. The outlook was not at all encouraging.

Within a very few weeks, however, the old fashioned panelled doors had become "moderne", the staircase had been enclosed, smartly designed lighting fixtures had been installed, the entire interior artistically painted, venetian blinds put up, linoleum put down, and new equipment put in.

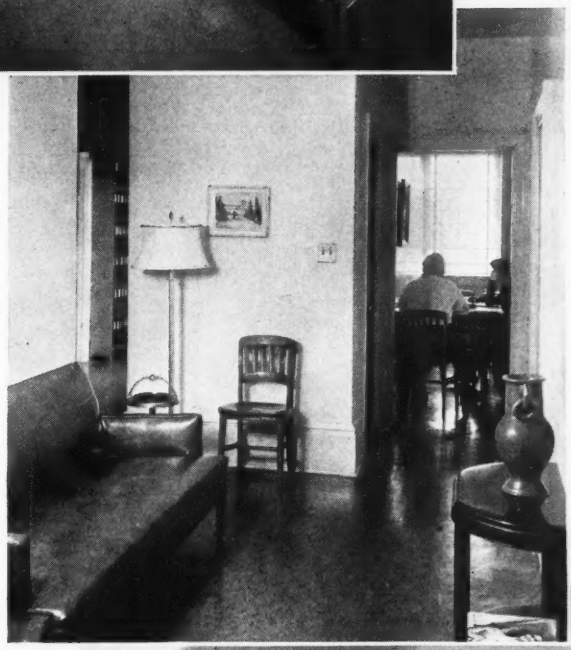
Now that the dust of moving has settled a bit, it has occurred to us that our readers might like to see what the new quarters look like. It was with regret that we left the offices on College Street, "home" of the Council since its formation in 1931, but our work has expanded so in the last few years that the decision by the University of Toronto to tear the building down only hastened a move which was inevitable.

In these days of housing shortages we are still amazed over having found a place at all, much less a suite of five rooms, airy and bright and in a convenient location. To be sure it is some forty steps up and there is no elevator, so that our visitors at times arrive a little out of breath. But at least we have room to work and store the files and put away the books which have been piling up alarmingly in the last few years.

Above: In the Inner Sanctum Mr. Agnew and Mr. Edwards discuss matters of high import.

oil paintings which decorate the suite. One rather lively picture shows an underground "nightspot" in Paris which he sketched at the time of the International Hospital Association meeting in Paris in 1937. Another painting reflects a different mood—a beautiful seascape which catches in minute detail the breaking of a huge wave on the seashore. This was done at Land's End, England. The main exhibit is, however, reserved for Dr. Agnew's private office. Here a panel of twelve paintings shows typical rural scenes, from Grand Manan to the Rockies. These are singularly appropriate from the viewpoint of the hospital-minded visitor in that they

Above: "Make-up Day" in the Journal Office. The cluttered table on the left, over which Miss Jessie Fraser is brooding so earnestly, contains dummy pages and galley proofs of "The Canadian Hospital" June issue. In the background Mrs. Eleanor Baker makes some last-minute revisions in the copy.

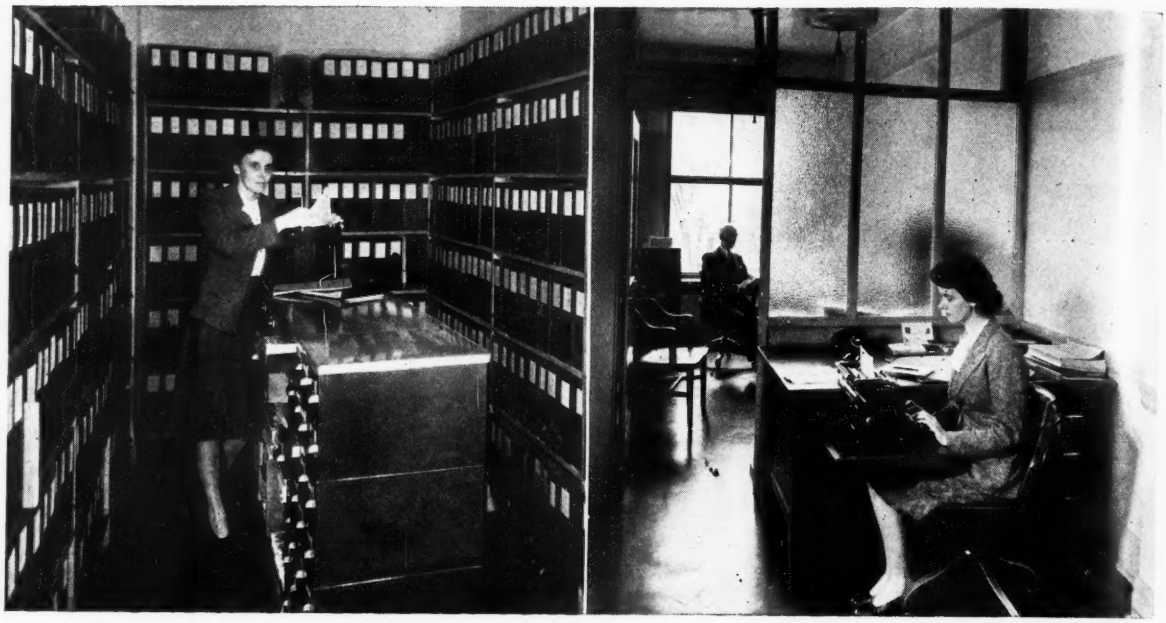


Left: The Entrance Hall gives visitors their first impression of the suite.

Below: The Secretarial Office. In the foreground Miss Jessie Duncan transacts some business via telephone. Mrs. Kay Beare, right, has charge of the financial and accounting end of our work.

Trying to find office furniture has been a discouraging business. Much of our former equipment had either been owned in common with the Canadian and Ontario Medical Associations or had been borrowed from them as need arose, and after the move it was necessary to buy such equipment for ourselves. Miss Duncan, on whose shoulders the responsibility lay, can now claim as wide an acquaintance among salesmen as any farmer's daughter in the land. However, we feel that the results justify her efforts.

Since Dr. Agnew will be out of town until after this issue has gone to press, we can safely refer to his



Left: The Library, presided over by Miss Ruth Skinner. Here replies to various requests for information are assembled and verified and package libraries made up.
Right: The Business Offices of the Journal, which are located at 57 Bloor Street West. In the foreground is Miss Margaret Cassidy, Mr. Edwards' very efficient secretary.

were all sketched by Dr. Agnew while attending meetings of various hospital organizations in the different provinces. These lovely paintings add to the new Council offices much of the personality of our Secretary who, as we all know, is a man of many parts and talents.

And now with ample space and facilities, and a competent secretarial and editorial staff, the Canadian Hospital Council has grown to mature stature. As always, it is our objective to serve the hospitals of Canada to the best of our abilities.

You are cordially invited to visit us at any time.

Right: Newest member of our staff, Mrs. Bird Carroll, at work in her office. The overflow of files and bound magazines from the Library have found sanctuary here.

Nutrition Program for New Brunswick

Ways and means of developing a broad nutrition program on a province-wide basis were discussed at the inaugural meeting of the New Brunswick Nutrition Committee held in Fredericton. Authorities in the fields of health, food and education attended the meeting. The guest speaker was Dr. E. W. McHenry, professor of public health nutrition, University of Toronto.

In his address, Dr. McHenry pointed out that nutrition, far from being a closed book, was a living branch of science and added that many avenues of nutrition research remained to be explored. The fact that the children of today were, on the whole, taller and in better physical condition than the youth of twenty years ago was given as a concrete example of the effects of improved food habits. The speaker outlined practical methods of conducting a community nutrition program and urged that, to be successful, such a program required the co-ordinated efforts of the departments of agriculture, health and education, plus those of interested people in the community. He said that the public must be made aware of the losses of food value, particularly in vegetables, caused by long periods of storage and transportation and by improper cooking methods.

British Hospitals and MEDICAL RESEARCH

DR. R. McNAIR WILSON,
Formerly Medical Correspondent, "The London Times"

MOST great British hospitals, like those in other countries, possess their research departments, and research is carried on continuously both in the wards and in the laboratories. The system is based on the idea that studies made in the wards should be supplemented by laboratory study and that discoveries made in the laboratories should be applied, and so tested, in the wards.

Two outstanding examples are the Cardiological Department at the London Hospital and the Cancer Research Department at the Cancer Hospital. The former was founded when Lord Knutsford, Chairman of the Board of Governors, invited Sir James Mackenzie, the most famous heart specialist of his day, to join the staff of the hospital and to carry on there his pioneer studies.

Sir James had wards assigned to him; he had also a department in which was installed an electrocardiograph and other special apparatus. His assistant was placed in charge of the instruments, while he himself dealt with the patients. He gathered together cases of various forms of heart disease and, when a complete clinical study had been made, the special instruments were brought into play. Then the evidence from the wards was co-related to the evidence from the laboratory.

Not less important is the study of cancer-producing substances now being undertaken at the Cancer Hospital. If there are cancer-producing substances there are also, presumably, cancer-restraining substances. As laboratory work on the latter proceeds it will be necessary to go to the wards for confirmation or disproof.

Research departments are staffed in Britain by whole-time medical officers who receive salaries and who rank as members of the hospital community. They enjoy complete independence within their own sphere of activity, but it is their duty to co-operate at all times with the physicians and surgeons, under whose direction, where patients are concerned, they work and practice. Thus, it is not the research officer who tests his discovery in the wards but the physician or surgeon in actual charge of the wards. This system places an effective check on excessive optimism and at the same time prevents any experimental work which does not seem to be fully justified.

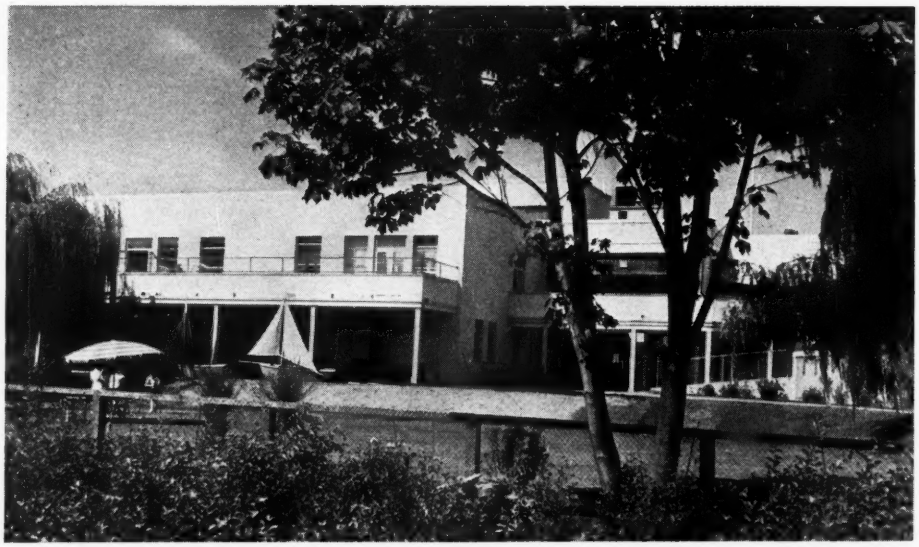
After the war of 1914-18 medical research in Britain found a new focus in the Medical Research Council, a body founded in 1920 which is controlled by the King's Privy Council. This Council has now established close relations with the research departments of all the hospitals as well as with dominion, Empire and foreign research departments. Under its present distinguished Secretary, Sir Edward Mellanby, it serves as a centre of information, not only for the laboratories but also for the wards. Thus the information derived from clinical research which is proceeding in, say, the United States, can immediately be applied in Britain, and vice versa.

Hospital research in Britain is also linked up with research at the Universities, notably those of Oxford and Cambridge, where great medical schools exist and where new research departments are constantly being opened. The latest of these—at Oxford—is concerned with sociology, that is to say with the kind of study on which every hospital almoner is daily engaged.

Sociology is research into the lives of patients as opposed to research into their diseases. But lives and diseases, as long experience has shown, are closely related. Indeed the study of health has become as much a function of the British hospital as the study of sickness and, in days to come, it is likely to become of even greater importance.

This is now the belief of the British Government, and the new health scheme has as its main object the prevention of disease by the promotion of fitness. In that scheme the British hospitals, from the curative, research and sociological aspects, are destined to play a conspicuous part.

Sir Edward Mellanby, secretary of the British Medical Research Council, at work in his laboratory.



The Psychology of Admission and Discharge

With Special Reference to Smaller Hospitals

W. N. MILLER,
Administrator, Crippled Children's Hospital, Vancouver, B.C.

BEFORE discussing admitting and discharge procedures, a useful purpose will be served by briefly discussing the Admitting Department itself and its personnel.

Dr. Malcolm MacEachern has described the admitting office as "the heart of the hospital" and also as the "dispatch system of the hospital". I cannot think of two more appropriate descriptions.

Dr. MacEachern has further stated:

> **"It is in the admitting department that the patient usually gains his first and lasting impressions of the hospital . . . It is, therefore, absolutely essential that the admitting officer have a thorough knowledge of applied psychology. Important also is the attitude of relatives and friends. The admitting officer in her contacts with these people must endeavour to gain their confidence as well as that of the patient . . ."**

Dr. Harvey Agnew has stated in his paper *Personality and Psychology in the Hospital* that:

> **"The psychology of dealing with the relatives is the rock on which many a hospital ship founders. The day of forbidding, iron-clad, prison regulations is definitely over and the patients are rightly treated as guests, not inmates. True, from the viewpoint of the busy nurse or the housekeeper, relatives may often appear as unmitigated and not always necessary nuisances; nevertheless much latitude and—always—the utmost courtesy must be shown. Much of the responsibility for creating a favourable impression rests upon the nurses and interns who bear the brunt of so many interrogations. Full explanations (where indicated) must be carefully and patiently made. The information clerk and the switchboard operator have an amazing influence, too, in moulding public opinion. The utmost care must be exercised in selecting personnel for these positions."**

In addition to the above general requisites for an admitting officer, he must have a thorough knowledge of the terms and provisions of the *Hospital Act* and the *Residence and Responsibility Act;* the procedures of the Indian Affairs Branch, the Workmen's Compensation Board, the Dependents' Advisory Board, the Department of Pensions and National Health, the Blue Cross Plans, etc. All these departments and organizations are revenue-producing to the hospital.

In the majority of hospitals in this province the secretary-treasurer of the hospital, as a rule, takes the necessary admitting information and makes proper financial arrangements.

From an address given at the Pre-Convention Instructional Courses before the last meeting of the British Columbia Hospitals Association.

Out-Patients' Clinic Wing.

He also takes the place of the "information clerk, switchboard operator and admitting officer" who are separate entities in the larger hospitals.

The Patient

Let us first analyse the patient. What are his feelings?

Dr. Agnew has said:

"We all know that patients who are physically ill are also mentally ill and that most people are suspicious of hospitals, to say the least, and perhaps prejudiced against them. The patient is introspective, anxious and critical; his illness is to him the most stupendous event since Noah ordered all hands ashore. He is impressed by minor incidents; a hasty personal word to him, or even a callous reception at the hospital; an unprepared room or perhaps the room or bed itself too cold; apparent delay at time of admission. The reaction of a patient must never be reduced to a formula. The hospital attitude must be delicately balanced, a mixture of cold science and warm compassion, of hard-headed business economy and cost-disregarding charity, of administrative services and yet with methods of such flexibility that efficiency is attained without friction or rancor."

Too often do admitting officers reduce every admission to a formula. The asking of direct questions such as: "What is your address? How long have you lived there? How are you going to pay your account?" etc., will only result in the patient's giving the admitting officer information which he thinks the hospital wants, whether it is factual or not.

The admission of patients should never be thought of as merely receiving and passing them through a fixed routine in transit to the ward. Every person admitted represents an individual personality, and the admitting officer, in order to carry out his responsibilities, has to do more than just get the name, sex, residence, religion and birthplace. For instance, in my opinion 95 per cent of all collections can be satisfactorily arranged at the time of admission of a patient. I do not mean that money is actually collected then—but rather, that proper and complete financial arrangements are made as to when and how the account is to be paid. The great majority of people are inherently honest and only in very few cases are promises not kept.

The Interview

The first procedure is to obtain the required statistical information. This can be done at the time of actual admission to the hospital, either from the patient himself or from the person accompanying him.

Depending upon the severity of the patient's illness, other information is obtained either at the time of admission or after the patient has been put to bed and made comfortable. However, before entering the patient's room, the admitting officer should ask permission of the nurse in charge. She should give to the admitting officer any pertinent information which may be of value to him, such as the condition of the patient, the probable length of stay in hospital (if such information is known to the nurse), etc.

The admitting officer can then interview the patient. He should first ascertain who is responsible for the payment of the bill. If the patient is responsible the officer should explain to him that he is not asking for money, but as there is a business side to hospital work, it is necessary to arrive at some financial arrangements for the payment of the account. A general conversation with the patient will often result in more

(Concluded on page 78)

Alcohol for Hospital Use

Recently we wrote to the associations stating that complaints had been received to the effect that certain distillers had not only increased the price of alcohol to hospitals but had notified them that amounts would be reduced by 50 per cent.

We have been notified by the Wartime Prices and Trade Board and also by the Dominion Inspector of Excise, Department of National Revenue, that Canadian distillers have been authorized as of January 1, 1946, to increase their price of alcohol by an amount not in excess of 30c per imperial gallon.

We are informed that although the Department of National Revenue has cut the total production of alcohol by 50 per cent, they had not indicated the basis upon which there should be a curtailment, if any, in sales. The department was of the opinion that there is sufficient alcohol for hospital needs even with the reduction in production. Our hospitals might approach other suppliers if they are being put upon a reduced quota.

Obiter Dicta

World Health Organization Needed

THE proposal to the United Nations Economic and Social Council by one of its special committees that a world-wide health organization be set up is one which should receive wide support. As the Hon. Brooke Claxton pointed out, this need was "dramatically brought home by our common experience during recent years". His deputy-minister, Major-General G. B. Chisholm, in presenting the report on behalf of Dr. Rene Sand of Belgium, noted that "The coming of air travel throughout the world will now largely nullify many of the protective barriers built up against the spread of diseases. No country can any longer depend solely on its own protective arrangements. Each must be assured of satisfactory controls in all other countries as well". No truer words could be spoken. The public generally does not realize how deeply our public health authorities are concerned over the ease with which unrecognized carriers of epidemic, tropical and other diseases, serious to man, beast or crops, can be admitted to this country by the present-day overnight flights of passenger or cargo planes from distant lands.

Based on suggestions made by China and Brazil last year, the report proposed the following aims and objectives: (a) to achieve the highest possible state of physical and mental health for all peoples; (b) to prevent the occurrences and to control the spread of disease; (c) to stimulate the development and improvement of health services, both preventive and curative; (d) to provide information, counsel and assistance to the field of health and medical care; (e) to achieve the highest possible level of education and knowledge in all subjects pertaining to health; (f) to weld together for effective action the scientific and professional groups which contribute to the advancement of health; (g) to contribute to the harmony of human relations.

The primary objectives of the proposed organization were re-stated by Mr. Claxton at a meeting held later in the same month (June). He suggested that other tasks which might well be undertaken could include the provision of uniform standards and nomenclature for drugs and medicines throughout the world and the maintenance of a statistical service on health matters. It will also be charged with giving immediate notice of the outbreak of epidemics, wherever they may occur over the world.

The report, prepared by a committee of sixteen recognized experts in the field of medicine, recommended that membership be open to all countries, whether members of the United Nations or not. This would seem logical if disease is to be controlled, although some opposition has already been noted. Mr. Claxton urged that the proposed body be set up at the September meeting of the United Nations General Assembly without waiting, as the report suggests, for ratification by at least 26 countries—a majority of the United Nations. Some discussion, too, may be anticipated as to whether there would be centralization of these activities in one world office, or whether there would be a looser federation of regional international offices, possibly utilizing already existing organizations. If the latter be considered, much care would be necessary to ensure that the existing services would give the best possible direction to these activities and would be sufficiently flexible and non-political to permit full co-ordination in world-wide policies. Undoubtedly the medical, nurse and hospital fields will be much interested in this development. Action taken may influence certain decisions which will be necessary soon respecting the revival, or replacement, of the old International Hospital Association. A new and more effective international hospital organization might well arise under the aegis of this new world health organization.

Atomic Bomb Injuries

A VALUABLE summary of the early and late effects of atomic bombing on the human body was presented by Captain Shields Warren, M.C., U.S.N.R., President of the American Association for Cancer Research, at a recent meeting of that body in Atlantic City.

Owing to the breakdown of the Japanese medical service at that time, accurate information respecting the immediate effects is far from complete. However in addition to the effects of air blast, flying debris, fire and crushing under collapsed buildings, there were two evidences of damage from the extensive release of radiant energy—flash burns and the effects of short-wave radiation and neutrons. The terrific effect of these blasts is revealed by the fact that 80,000 people died at Hiroshima and 45,000 at Nagasaki.

The wave of heat was so intense and so fleeting that, although it caused second and third degree burns, clothes or hair were sufficient to protect areas. The profiles of blades of grass were etched against scorched boards. Owing to inadequate treatment many of these burns have resulted in serious contractures. Immediate radiation effects resulted in weakness, malaise, fever and often death, usually within 48 hours. Morphologic evidence was chiefly leukopemia and loss of adrenal lipoid.

Delayed effects have been more readily studied. Damage was chiefly to the blood, hemopoietic tissues and the gonads, with some injury to the hair follicles. Three types of blood change were noted: leukopenic changes associated with infections and particularly Ludwig's angina (white counts as low as 200 were noted); hemorrhagic conditions resulting from the thrombocytopenia, ranging from petechiae and ecchymoses to massive hemorrhages; and later anemic manisfestations with red counts as low as one million or even less. Bone marrow samples showed both hyperplastic and aplastic changes. The gonadal effect on the testis was much more intense than that on the ovary, serious atrophy of the germinal epithelium being noted. Examination of a number of individuals who had entered the bombed area soon after the explosion and remained there revealed no deleterious effects. Captain Warren believes that the long range results of this exposure can only be determined by continued study of individuals exposed for many years to come.

New Type of Publicity

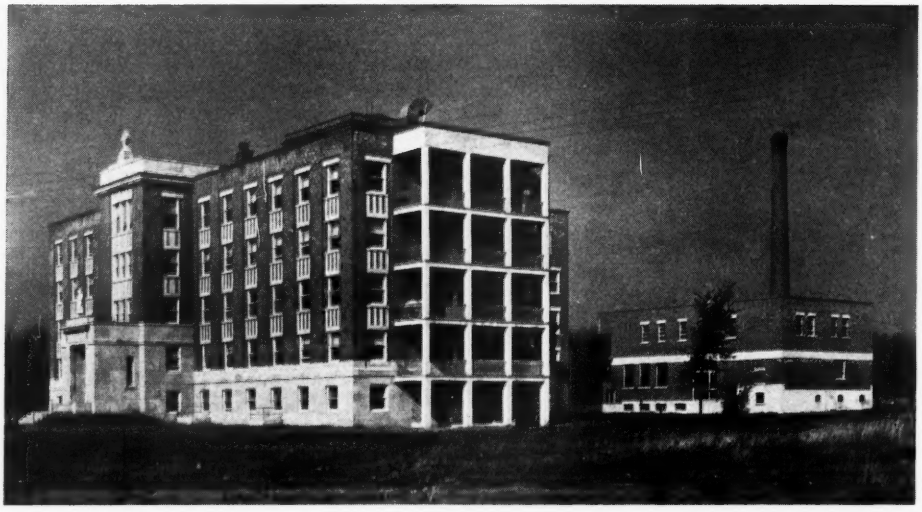
THE basic requirement of any type of written publicity, be it for hospitals or otherwise, is to have that publicity read—not thumbed over but *read.* We have been intrigued by an attractive booklet issued by the Newton-Wellesley Hospital in Newton Lower Falls, Mass., where Mr. C. H. Walker is president of the Board and Mr. Gerhard Hartman (fromerly of the A.C.H.A.) is administrator. We warrant that this has been widely read.

Entitled "What do YOU think?" this booklet presents, by diagram and punchy paragraphs, the opinions of the people in the area respecting their hospital and its activities. People have their own opinions about the hospital—its service, its charges and its appeals—and they are keenly interested in seeing how their opinions, favourable or critical, compare with those of their neighbours. By the use of cleverly-drawn cartoons and charts and by using two colours of ink, the community votes are so presented that even those who cannot take time to read the further explanation can get the story from the pictures.

The results are revealing and this record of community opinion, seldom obtained by hospital boards, is one of which the management may be proud. For one person who states that he would not go to the hospital if ill, nine say they would. Asked where they would like to have a child born, 3 per cent said "at home", 78 per cent at this hospital and 19 per cent at some hospital elsewhere. Asked their candid opinion respecting the efficiency of the hospital management, only 6 per cent believed the management to be inefficient. Asked whether the hospital was large enough, 80 per cent replied "No". Only 43 per cent thought that the school of nursing had adequate training and housing facilities. It was informative to find that 31 per cent thought that the Board of Trustees received compensation, either as salary, discounts or in some other form. Likewise 55 per cent had the idea that staff doctors were paid for treating ward patients and outpatients.

As for hospital charges, 87 per cent thought them "fair", one per cent "low" and 12 per cent "too high". To meet the situation when income from all sources proves inadequate, 2 per cent would cut expenses regardless of standards, 97 per cent would appeal to the public for contributions and one per cent would let the hospital run into debt. Only 19 per cent failed to realize that the hospital did not receive enough from paying patients to finance enlargement. Although 34 per cent were not members of the Blue Cross Plan, 76 per cent voted against any compulsory plan replacing the voluntary plan. If responsible for meeting hospital operating expenses, only 43 per cent would require payment in advance; the others would give credit and attempt to recover where necessary. It was significant that 97 per cent favoured the most advanced medical facilities even though costs would be increased. Also 93 per cent thought certain sections of the hospital should be modernized or enlarged. As for building funds, 62 per cent would appeal to the public, 25 per cent to the city and only eight and five per cent to the federal or state governments. Some 85 per cent would leave a bequest to the hospital in their wills—an inspired suggestion.

This information should be exceedingly valuable to the Trustees in their public relations work and is a local study which might well be repeated by many hospitals.



St. Joseph's Hospital at Granby Completed

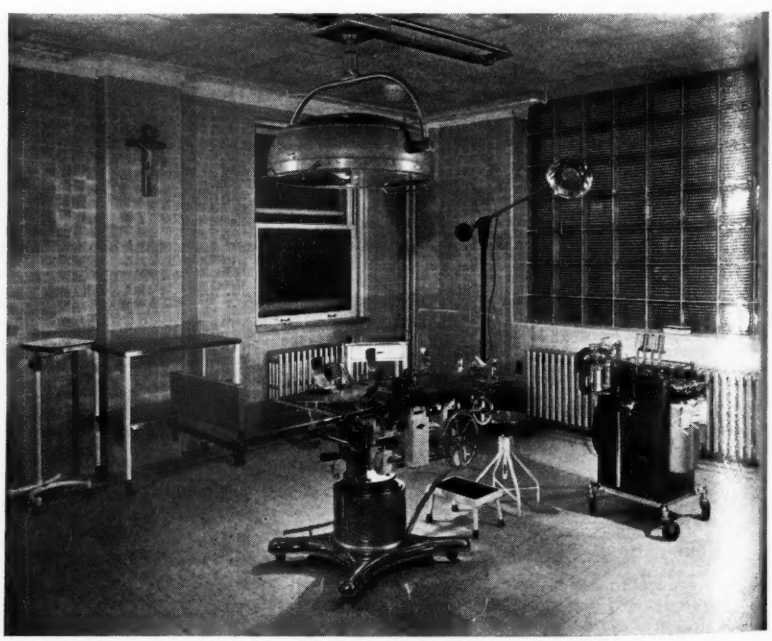
BEGUN in the fall of 1943, and opened for patients late last year, the new St. Joseph's Hospital at Granby, Quebec, is a fine up-to-date institution and reflects great credit on the sense of civic responsibility which brought it into being.

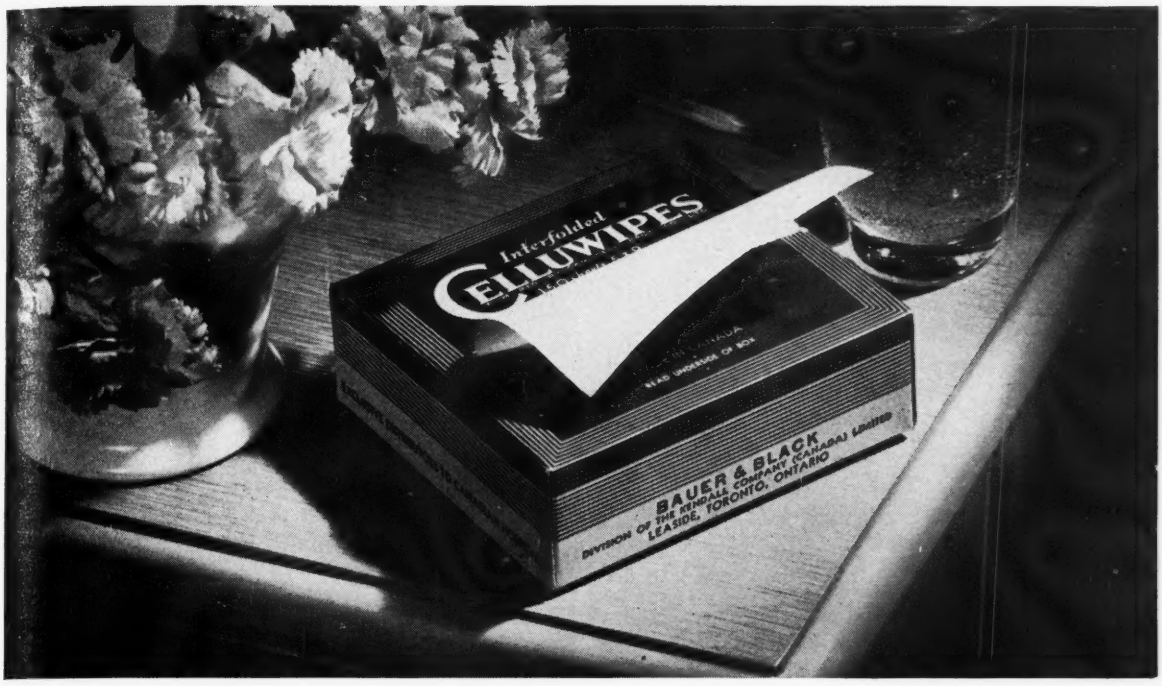
The 150-bed hospital is entirely fire-proof, and the walls are sound-proofed throughout. A feature of the construction is the four spacious sun-porches at one end of the building, serving each of the four floors. Fully-automatic, silent operating elevators serve the main building, while the extensive power plant is housed in a separate building at the rear.

Generous use has been made of terrazzo, porcelain tile and glass brick in the construction of the hospital, which has resulted in a cheerful, inviting atmosphere. Fluorescent lighting has been used throughout, including the modern kitchen with its latest-type electrical equipment and two walk-in refrigerators. Steam-heated portable serving tables convey the food to the patients.

Facilities include an operating room and x-ray room, and a special feature is the little chapel, where mass is celebrated daily. Twenty-six comfortably furnished rooms are provided for private patients, while the sunny nursery contains thirty bassinets.

The architect in charge of construction was Mr. Jean-Julien Perrault, F.R.A.I.C. The hospital is under the direction of the Grey Nuns, and Rev. Mother Roy is administrator.





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RESEARCH TO IMPROVE TECHNIC . . . TO REDUCE COST

Present Day Conditions *in a* Large Hospital Laundry

G. RUDDICK,

Laundry Superintendent,
Vancouver General Hospital

THE maintenance of adequate laundry service in our hospitals during the years since 1939 has presented many a headache. In our own hospital the poundage has increased steadily. For instance, in 1941 it was 2,505,889 pounds dry weight laundered, while by 1945 it had risen to 3,002,409—notwithstanding the fact that our nursing staff and other departments have been most co-operative in their efforts to keep the laundry poundage at a minimum. Linen per patient per day averages seven to seven and a half pounds (most hospitals, I believe, use ten or more pounds).

Starting late in 1937 and continuing until spring of 1939 the administration introduced an expansion program and the laundry was equipped, at a cost of approximately $65,000, with a new washfloor, Monel washers, 48" extractors and some new steam airdriven presses. At that time we were processing between 20 and 23 tons of linen per week, with a payroll of approximately 45 employees working 43 to 45 hours a week. It was felt that, if it became necessary, we could increase the output to 30 tons per working week by engaging a few extra employees working a full 48-hour week. In February 1945 we exceeded the anticipated capacity of 30 tons per week, and it became necessary in the next few months to go beyond this point by inaugurating a swing shift two nights a week with about half our equipment operating. During the past five months increased volume has necessitated extending this shift to four nights a week and operating practically all our equipment, producing 67,000 pounds a week.

Present Conditions

We are currently employing about 55 employees on the day shift and 20 to 25 employees on the swing shift. We believe this to be the capacity of our present plant; in view of still greater volume to come we have drawn plans for the extension of our present building and installation of equipment suitable to future requirements up to 40 tons per week.

A feature which may be of interest is that we operate the plant on a production basis, as recommended by the American Institute of Laundering in a survey made by them in 1937. While at present efficient labour is very hard to obtain and our production per operating hour is not entirely satisfactory, we feel that the production standards and pound cost are holding fairly well.

Washroom

Rough-driers

Our present labour cost is 1.8 cents per pound. Including supplies, energy and supervision brings the rate to 3.4 cents per pound (dry weight, which we feel is quite good under present conditions. We make one very definite saving in our laundry supply cost by manufacturing our own soap. The necessary tallow is obtained from our dietetic

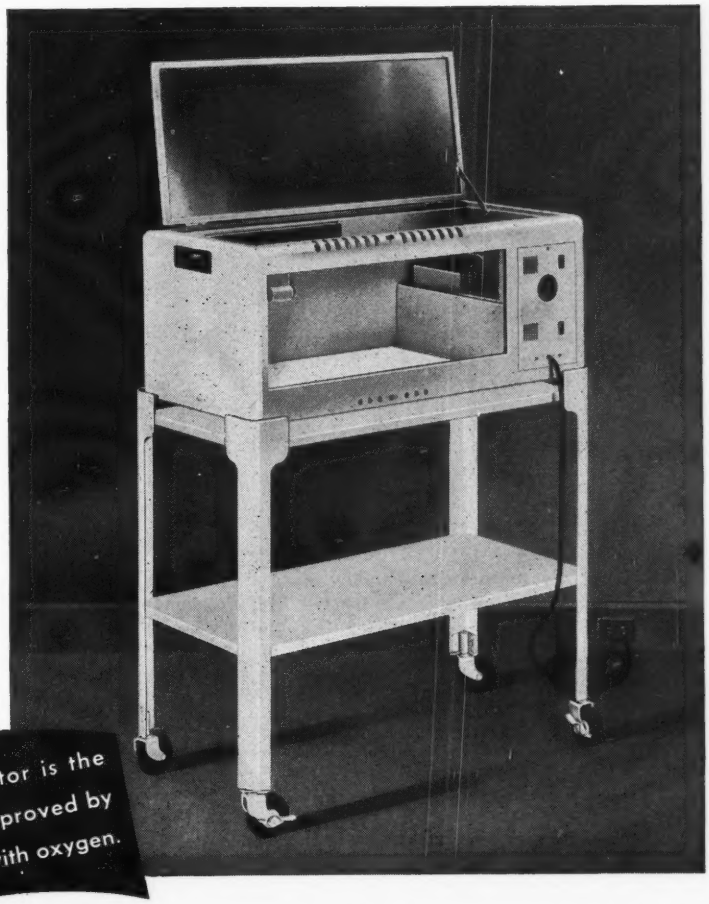
(Concluded on page 46)

ARMSTRONG X-4 PORTABLE BABY INCUBATOR

LOW COST

SIMPLE

SAFE



The Armstrong X-4 Baby Incubator is the only Baby Incubator tested and approved by Underwriters' Laboratories for use with oxygen.

Low cost • Underwriter approved • Simple to operate • Only 1 control dial • Safe, low-cost, heat • Easy to clean • Quiet and easy to move • Excellent oxygen tent • Fireproof construction • Ball-bearing, soft rubber casters • Welded steel construction • 3-ply safety glass • Full length view of baby • Simple outside oxygen connection • Night light over control • Automatic control • Safe locking ventilator • Safety locked top lid • Both F. and C. thermometer scales • Low operating cost • No special service parts

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department, and at present we are producing about 12,000 pounds a month. Many laundry operators feel that an efficient washing soap cannot be manufactured on this basis. We have found otherwise, however, and the results both in tensile strength loss and detergency value are very satisfactory.

To substantiate the above statement we submit the following recent tests conducted by the Canadian Research Council at Ottawa on a test bundle processed twenty times in our plant, as follows:

Detergency Test .....99.0 per cent
(C.R.C. comment "Excellent")
Whiteness Retention Test
..... 99.6 per cent
(C.R.C. comment "Excellent")
Tensile Strength Loss
.....less than 5.0 per cent
(C.R.C. comment "Excellent")

This, we believe, compares favourably with any commercial or institutional laundry.

Colour

An editorial by Professor Eric Arthur, Editor, "Journal of the Royal Architectural Institute of Canada".

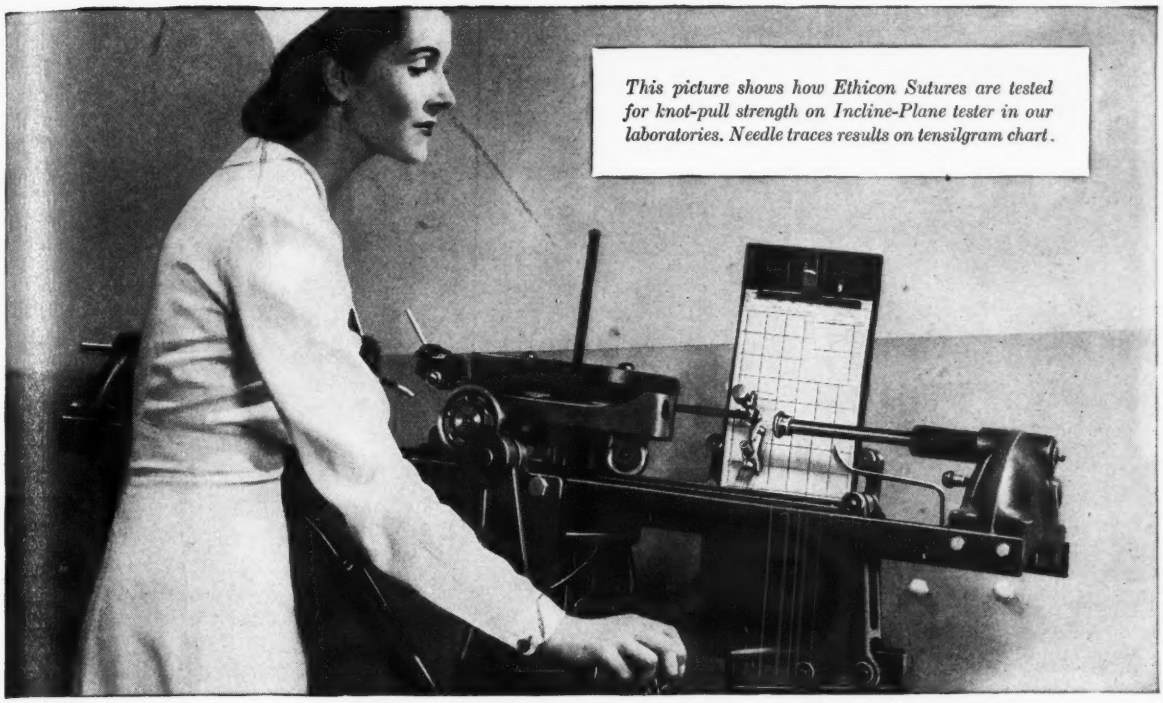
THE Victorians have been blamed for a good many things, some of them undeservedly, but there is one field in which their influence was malign and far reaching. We refer to colour. The Victorian house owner thought of his home in much the same terms as someone has spoken of Frank Lloyd Wright. He did not go home in order to look out on nature, but rather like an animal to its lair. He entered a cave from which, with the closing of the front door, the outer world was shut out. Inside, wood trim and panelling were dark, wall papers of the most effective light-absorbing colours lined the walls, and heavy curtains and portières insulated and isolated the family as in a tomb. A new generation, with a new broom, has transformed the few mausolea of the period that remain and, for the connoisseur, the only examples left to contemplate are to be found in men's clubs. It is a curious fact that the better and more exclusive the club, the more forbidding and dreary is the interior. For the student of the history of taste, Toronto provides many excellent clubs with those peculiarities, but Toronto has no monopoly in them. Montreal, Hamilton, Ottawa, Winnipeg, Vancouver, can all point with pride, and a certain awe, to dingy edifices where the food, usually, is as good as the surroundings are bad.

We suppose that the schools and hospitals of the last century were as dismal as any of our public buildings. From the outside, they looked like the English work house, and the inside, usually, did justice to the exterior. It would seem as though school boards wished to impress on the inmates that they were receiving their education at public expense; and hospital patients, at any rate in the public ward, were always made conscious of the fact that they were a civic charge, or nearly so. For such persons the English work house and infirmary had set a standard of drabness that made it quite clear that the inmate was not to enjoy himself. This practice we followed, and across the land are schools and hospitals, still with chocolate brown or olive green dados and muddy coloured walls. It was considered an atmosphere in which one could study, or get well, without distraction or a nervous breakdown.

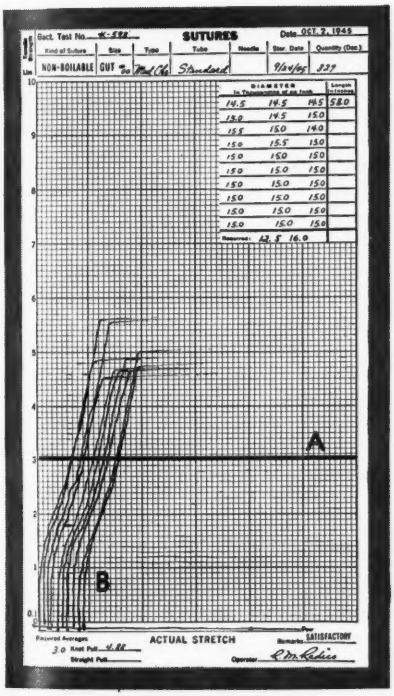
Wards in Pastel Tones

Today, these notions are happily in the discard. In Toronto, always in the lead in the search for gayer and fuller life, we have a civic hospital in which the wards are painted pastel shades that would not look amiss in a beauty parlour, and the mortality statistics have not been noticeably affected. The Tubercular Sanitorium, in Waukegan, is an excellent example of colour, scientifically used to produce a most cheerful and restful atmosphere. In *Time,* we read of similar experiments in New York Schools. There, experiments have been carried on since 1943, and this year the tested ideal classroom colour of peach and rose was announced. Chalk board walls are light or dark in colour as a focal centre, and glare is minimized by painting window walls brighter than side walls.

In every field of human endeavour, the same interest in colour is being shown, and we hope that some day, soon, a large paint manufacturer will produce a colour catalogue that will be of use to the people who are using his paint. The colossal books that the architects have received during the war, and recently, are quite useless except to help some poor untutored little woman to make the best of her bathroom or brighten up the kitchen. We can visualize a catalogue that hundreds of architects would cheerfully pay ten dollars for, but it is not yet in sight.



This picture shows how Ethicon Sutures are tested for knot-pull strength on Incline-Plane tester in our laboratories. Needle traces results on tensilgram chart.



Heavy horizontal line (A) on tensilgram chart marks U.S.P. minimum average value, knot tensile strength, (3 pounds).

Rising curved lines (B) show actual breaking points of Size 00 Ethicon Catgut, substantially above U.S.P. average minimum.

Chart demonstrates greater Ethicon strength as well as unusual strength uniformity. Note breaks occurring within narrow strength range, 4½ to 5½ pounds, assuring greater uniformity of strength.

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1. Knot breakage reduced to a minimum.

2. Foreign body reaction reduced. Many surgeons will find smaller sizes adequate.

3. Catgut now usable in many new situations, with smallest sizes ever made (True 6-0 and 5-0).

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● New fields of usefulness are opened for absorbable sutures with 6-0 and 5-0 gauges. These new sutures, with knot tensile strength up to 60% greater than U.S.P. requires, have received extensive clinical tests by leading specialists. They should be particularly useful in gastro-intestinal, eye, neuro, plastic, and infant surgery.

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SUTURE DIVISION

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Civilian Hospitals and the War

Prepared by the Secretary of the Canadian Hospital Council and included in a brochure on medical services during the war distributed to those attending the Canadian Medical Association Convention at Banff in June.

THE civilian hospitals were much affected by the war, more than may have been generally realized. Although connected only indirectly with the actual prosecution of the war, the contribution of the civilian hospitals in personnel, in educational facilities and in the maintenance of civilian morale cannot be overestimated.

Personnel Shortage. The depletion in personnel was staggering. Staff doctors, nurses, residents, technicians, dietitians, administrators and employees in general left in large numbers for the Armed Services. Many employees left to enter war industry. In the case of some of the smaller hospitals, the enlistment of an outstanding surgeon meant a serious financial situation for the hospital. Highly trained personnel could seldom be found as replacements and many of the sub-staff taken on were without training or experience and not physically fit for the work undertaken.

Under such circumstances the hospitals have had a trying period. Staff doctors have had to work harder than ever before; with no interns, or junior ones only, more work has been thrown on the staff. Administrators have been distracted trying to keep departments functioning; food service, for instance, has been difficult to maintain. Administrators of large hospitals have reported as high as seventy-five absentees without notice on a single morning—in large part irresponsible employees, frequently temporary, who had left without warning for other employment. Some smaller hospitals have had to close down, mainly because of lack of nurses. Others have had to close wards, despite waiting lists of patients. The work of those faithful employees who stayed on was made more difficult because of a greatly increased demand for beds, and less advantageous conditions of work due to overcrowding and worn-out equipment.

Increased Demand for Beds. The increased demand upon hospital facilities was due to a combination of factors—crowded home conditions, more people away from home, lack of domestic help, increasing complexity of medical diagnosis and treatment, overworked doctors, development of hospital care plans, greater family incomes and, in Alberta for instance, legislation providing hospitalization without charge for maternity care. The National Health Survey revealed an increase in hospitalization of 19% during the period from August, 1939 to January, 1943, with a peak of 32% in New Brunswick and 42% in Nova Scotia.

Sharply rising costs made the situation very difficult for administrators and for the trustees, many of whom were facing serious readjustments in their own businesses. Schools of nursing were enlarged to meet the increased demand for nurses and, of course, this meant additional strain upon the directors and instructors. Replacements of equipment became difficult and repairs very unsatisfactory, if possible at all.

Mirabile Dictu. Under the circumstances the wonder is that hospital service could have been maintained with so little interruption and with, on the surface at least, no deterioration in the quality of the service. This is a real tribute to the conscientious and faithful service of all who had to do with the care of the sick and the operation of hospitals. Tribute must be paid to the large number of volunteers who came early and late, and regularly, to help the regular staff in their varied tasks. The women's aids, too, despite many other self-imposed tasks, maintained their enthusiastic support of hospital assignments.

War Activities. The hospitals did a great deal that was more directly related to the war. They hospitalized many patients in uniform. Their professional and lay staffs provided for the teaching of Red Cross and St. John's Ambulance courses in home nursing and first aid work; took an active part in A.R.P. organizational work; spent long extra hours at canteens, hostess houses and other wartime services; gave freely of their time at blood-donor clinics; assisted the Canadian Medical Association, the Canadian Hospital Council, the Canadian Nurses' Association and the respective provincial and regional hospital medical and nursing organizations in a wide range of special activities. Particularly should mention be made of those public-spirited administrators, staff doctors, nurses and others who gave so freely of their energy and time to the work of the Canadian Medical Procurement and Assignment Board, to the Divisional Advisory Committee, and in an advisory or consultant capacity to the Armed Services, to National Selective Service, to the Department of Munitions and Supply, and to the former Department of Pensions and National Health, now divided.

Other Undertakings. Despite these extra activities and the abnormal difficulties of day-by-day operation, the leaders in the civilian hospital field found the time to work closely with the Federal Government (and several of the provincial governments) in a constructive study of various angles of health insurance. In several of the provinces, too, the hospitals have taken the lead in developing much needed voluntary plans for hospital care. An outstanding example is the Plan for Hospital Care (Blue Cross), set up five years ago by the Ontario Hospital Association. Already this plan has nearly 600,000 participants.

Our civilian hospitals can be proud of their wartime services and achievements!

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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

The National Health Service Bill is making good progress through Parliament. At the outset the Conservatives were inclined to contest it vigorously. Mr. Richard Law was chosen to make the attack and, after having accused the Minister of lack of knowledge of the subject, seriously misquoted a document, of which he had no copy among his papers, so that one had to be supplied to him from the Government benches. The fact of the matter is that the Opposition have been made to realize the necessity for an extensive re-organization of the health services and in particular of the hospitals. Moreover the personality of the Minister has been an important factor in the situation. Mr. Aneurin Bevan with the responsibility of office is a very different person from the firebrand, as he was generally regarded, when in opposition. The Chairman of the voluntary hospital, for example, who is principally concerned in taking over the hospital at Cliveden, which Canada has so generously given to this country, told me that he found the Minister to be most reasonable as a negotiator and charming as an individual. The result so far as the Bill is concerned is that Mr. Bevan has shown himself to have adopted a middle course, which is far less than many of the supporters behind him on the Government benches desired, in order to make the Bill acceptable to the Opposition as far as possible. Accordingly there is every anticipation that it will have passed into law about the end of July, though its operative date cannot be until January 1st, 1948. In the meantime there is much to be done, and the minds of many immediately concerned are being turned to the practical problems involved in bringing the measure into effective operation.

Professor Mackintosh, who came from Scotland not long since to take up the important post of Professor of Public Health in the University of London, has pointed out that the

Lay or Medical Administrators?

establishment of the regional hospital system contained in the Bill "will inevitably foster the demand for medical administrators". *(Lancet, 25 May 1946)*. At the same time he recognizes that "there will be great scope for lay administrators". The layment have already anticipated this demand to some extent. In fact the various bodies concerned have been drawing together for some time and are now united in one organization, which embraces voluntary hospital officers together with the lay officers of mental hospitals and the general hospitals under local authorities. Thus the officials have anticipated the co-ordination which is about to take place under the operation of Mr. Bevan's Bill. Steps have already been taken to provide a suitable form of training, and Professor Mackintosh argues "that the best way to encourage people to work together at the same job is to train them together, in order that they may understand one another's problems and points of view". Hitherto the lay administrator has been chiefly in evidence in the voluntary hospitals while the mental and municipal hospitals have had medical men for their chief executive officers. This applies particularly in England, as the Scottish voluntary hospitals in many cases are more accustomed to a medical chief administrator. Professor Mackintosh realizes "that some controversy has arisen from time to time over the respective spheres of medical and lay administration" and considers that it is due to a lack of definition of their respective spheres.

The new Act, however, will introduce a new factor into the situation and it may be doubted whether the Professor's paper in the *Lancet* lays sufficient stress upon it. He bases his argument upon the administration of the institution, whereas the proposed planning will involve large-scale administration calling for a wider outlook and a different type of ability. During the war the officials in charge of the regional administration were mainly medical men, though there were exceptions, and that involved a considerable sacrifice of medical skill. The main reason for that choice was not so much that they were possessors of medical qualifications as that they were men of broader education and wider experience in handling men and the management of affairs. The case for a medical administrator of a hospital, where he has the responsibility of life and death of individuals is much stronger than for the organizer and planner of a region which, indeed, might be carried out by a man from the public health service.

The subject of "medical administration as a career" to which Professor Mackintosh has devoted his paper is closely bound up with the much larger problem of training administrators. This still remains unsolved in spite of the many attempts to tackle it, and in fact has recently become the subject of new experiments. The fact of the matter is, as the Professor observes, that "what we must try to teach the

(Concluded on page 80)

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Here and There

Norman Bethune, M.D.
1889-1939

(Condensed from an article by Dr. F. H. Fish in the "Historical Bulletin" of the Calgary Associate Clinic).

MORE often than not recognition in one's own country comes only after death and this paper is essentially a tardy obituary; one of a man whom some of you have known as a demonstrator in surgery but whom most of us know only from his association with what were, to all appearances, lost causes—a champion of the under-dog—Henry Norman Bethune. In the later years of his comparatively short life, he made such an impression upon the peoples of Spain and of China, with whom he had not even language in common, that he will be held in semi-adoration by them for generations to come.

Bethune was born in Gravenhurst, Ontario, and studied medicine at the University of Toronto, interrupting his course to join the first Canadian contingent in 1914. He was wounded at Ypres and after being invalided home completed his medical training. Later he went to Edinburgh where he achieved a fellowship in the Royal College of Surgeons.

In 1926 he was afflicted with active tuberculosis and spent a year resting at Saranac Lake. It was during this year that expression was given to two latent talents in Bethune—art and literature. His cottage was lined with wood-panelling, some sixty feet of wall space and in each of nine panels he painted murals which he designated as "A T.B.'s Progress". These portrayed life from the foetus to the grave and to each 'stage' was attached a bit of satiric verse, revealing a despondency natural enough in the circumstances.

Marked improvement in his condition was brought about by pneumothorax and a year later Bethune went to the Hospital for Incipient Tuberculosis at Ray Brooke where he galloped through a course in bacteriology. From Ray Brooke he went to Montreal where he was attached as first assistant to Dr. E. W. Archibald in the chest service at the Royal Victoria. Three years later he opened his own chest service at the Hôpital du Sacrè-Coeur at Cartierville and the following period prior to his departure for Spain was one of the most fruitful in his career. His imaginative mind, coupled with capable hands, made for far-reaching

modification in technique and as a result he not only designed instruments but made some rather daring excursions into treatment.

But the driving force of Bethune's personality was not satisfied by either professional or monetary success. He was essentially the Crusader —for the man on the street. As a keen student of sociology and social economy, he could not help but be interested in the social aspects of medicine. The rehabilitation of the tuberculous and the provision of adequate medical care for them were causes always close to his heart. While in Montreal, he gathered around him the younger members of the profession in a sort of discussion club, their main topic being the provision of medical care for the economically unfortunate and this culminated in the organization of the Montreal Group for the Security of the People's Health, of which he was secretary.

In 1934 Bethune visited Russia where he became imbued with further ideas on social medicine and at the outbreak of the Spanish Civil War he volunteered for service under the Loyalist party. He found that the most pressing need in Spain was a transfusion service of some sort. By dint of hard work and appeals to Canada for funds, he evolved presently the first workable blood-bank in the world; one to which was attached a delivery service composed of refrigerator-equipped cars through which blood was despatched over the entire Loyalist front centering on Madrid. Bethune's accomplishments in the face of the desolation and hopelessness of the Spanish situation provided the foundation on which was to be built our conception of the blood bank, the mainstay of our resuscitation therapy in the war just ended. Without his experience in Spain and the knowledge which he was able to hand on, many many men who are safe in their homelands today might well be lying in foreign graves.

With the transfusion service established in Spain, Bethune's attention was drawn to the Chinese scene and he went to the Orient under the sponsorship of Canadian and American sympathizers. He and a nurse—his whole original staff—were attached to the 8th route army which was actually a guerilla army with transport by mule. With this outfit he moved and had his being while in China. His letters give some detail of his life with these troops, the appalling conditions under which he worked and a deep underlying nostalgia for his own people and a civilized way of life.

"It's a fast life . . . I miss tremendously a comrade to whom to talk . . . I don't mind the conventional hardships—heat and bitter cold, dirt, lice . . . I find I can get along and operate as well in a dirty Buddhist temple with a twenty foot high statue of the impassive-faced, gilded god staring over my shoulder, as in a modern operating room . . . "

Again he writes, "I dream of coffee, of rare roast beef, apple pie and ice cream . . . Books—are books still written? Is music still being

(Concluded on page 80)

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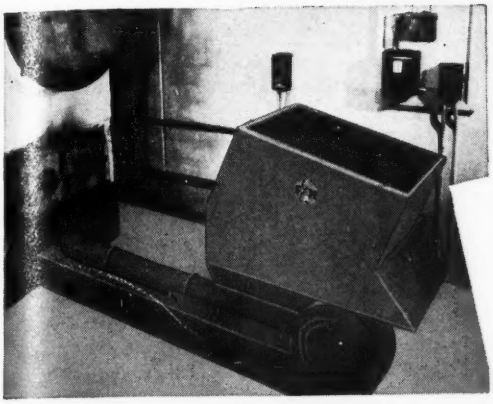

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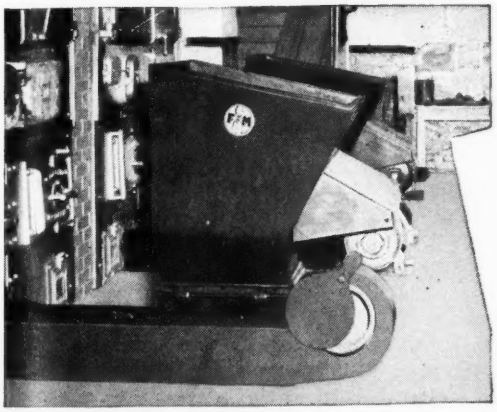

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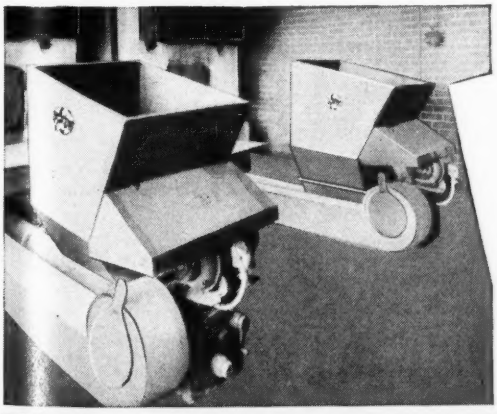

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Book Reviews

WHAT YOU WANT TO KNOW ABOUT NURSING. 34 pp., illustrated. Prepared by the Canadian Nurses Association, 401, 1411 Crescent Street, Montreal 25, P.Q.

This booklet has been compiled for the guidance of first and second year high school groups in selecting subjects for study which will qualify them for entrance to schools of nursing. Many of the points covered were raised by students themselves in a recent survey made by the Association. The educational qualifications required for entrance to schools of nursing in the various provinces are outlined and a detailed listing is given of opportunities open to graduate nurses in special fields. The section on the life of a student nurse is illustrated with photographs of students at work and others enjoying leisure hours. The book should do a great deal toward encouraging girls to enter the nursing profession and will be of value to guidance counsellors, teachers and others who are in continuous contact with the teen-age group.

* * *

A REVIEW OF NURSING (5th Edition), by Helen F. Hansen, Reg.N., M.A., Executive Secretary, Board of Nurse Examiners, Department of Professional and Vocational Standards, California. Pp. 854. W. B. Saunders Company, Philadelphia, McAinsh & Co. Ltd., Toronto. 1946.

This new edition of the classic "questions-and-answers" review first published in 1934 incorporates some new developments in the outlines and contains some supplementary material. Increased emphasis has been placed on *positive health* of the individual, family and community. A new technique of imaginary case reports has been adopted, combining situations and questions. Preventive measures have been stressed throughout the book.

* * *

THEORY AND PRACTICE OF NURSING, by M. A. Gullan, S.R.N., Member of the College of Nursing. Pp. 236, illust. Price 12s. 6d., net. H. K. Lewis & Co., Ltd., 136 Gower Street, London W.C. 1. 1946.

This little volume packs an unbelievable amount of information into its two-hundred-odd pages. It summarizes the instruction on the theory and practice of nursing given in the training school of St. Thomas' Hospital. No attempt has been made to treat individual procedures and techniques exhaustively. Rather the aim has been to provide a working text book, to be amplified from the nurse's own experience. In this it has succeeded admirably. It is thoroughly up-to-date, including paragraphs on the latest drugs, etc.

* * *

MINE OWN EXECUTIONER, by Nigel Balchin. Collins, $2.50.

This novel is a bold foray into the exciting field of psychosomatic medicine. It makes good reading for anyone who enjoys seeing the orthodox medical practitioner caricatured and equally good reading for those who have no love for the psychiatrist. In fact, one lays it down wondering just why the author wrote the book.

The story centres around a young psycho-analyst for whom the reader's sympathy is immediately roused by the fact that, lacking funds to finish his medical course in an English school and at the same time to take post-graduate work in psychiatry, he chose to study for three years in Vienna under the famous Loewe. He started to practise as a lay practitioner in collaboration with a group of qualified medical doctors who had established a charity clinic in psychiatry. This situation gives plenty of scope to the author to analyze relationships between the newfangled lay practitioner and the more orthodox medical men; between the practitioner and his patients; between the practitioner and his wife and friends. His great test comes when his most difficult patient commits murder and so brings him under the eye of the law. At this point, the reader expects the great justification of the hero. Instead, he displays a psychological immaturity which brings him to the brink of ruin. He is saved by one of his medical colleagues. This man displays a cultivated judgment and sound common sense which saves the day for the reader as well. Perhaps *this* is the point of the book—that sound training is worth while. As an ending to the story, it is most surprising.

The story is skilfully and entertainingly told. The author is an industrial consultant by profession and rose to be a brigadier in the last war. He has published two other books with success.—H.S.A.

* * *

MEDICAL SERVICES BY GOVERNMENT, Local, State and Federal. By Bernhard J. Stern, Ph.D. Pp. 208. Price $1.50 (U.S.). Published by the Commonwealth Fund, 41 East 57th Street, New York, N.Y. 1946.

This volume is the latest in the series being issued by the New York Academy of Medicine Committee on Medicine and the Changing Order. The author traces the development of governmental action in the field of medicine, from the awakening of a "community conscience" to the plight of the indigent sick in colonial days to the present elaborate social security programs.

While full of interesting information and well written—like the others in this excellent series—this book is directed to American readers more than to Canadian.

Coming Conventions

July 22-26—A.H.A. Institute on Theory and Practice of Cost Analysis in Hospitals Indiana University School of Business, Bloomington, Ind.

September 9-13—A.C.S. Hospital Congress, Waldorf-Astoria, New York City.

September 28-30—American College of Hospital Administrators, Philadelphia.

September 30-October 4—American Hospital Association, Philadelphia.

October 21-24—Ontario Hospital Association, Royal York Hotel, Toronto.

October 28-November 2—Institute on Administration and Convention, Manitoba Hospital Association, Royal Alexandra Hotel, Winnipeg.

November 5-6—Saskatchewan Hospital Association, Saskatoon.

November 6-8—Associated Hospitals of Alberta, Palliser Hotel, Calgary.

November 12-15—British Columbia Association, Vancouver.

The Pastor—
and the Hospital Patient

IN the rapid development of our modern hospitals we have almost outdistanced the pastor in his efforts to fulfil his traditional obligations to the sick.

But the pastor has an important place in the sick room whether it is in the home or in the hospital. This patient-pastor and the patient-chaplain relationship can almost be compared to the patient - family doctor and patient-specialist relationship in which the family doctor is not entirely divorced from his patient.

The need for a pastor in the home of the sick and bereaved is denied by no one. But although modern society has moved the seat of serious illness from the home to the hospital, the change in locale does not eliminate the need for the pastor. The same factors that caused him to be needed in the home are present in the hospital, plus the added factor of a strange environment.

Sick people need a clergyman because the appendix, the gall bladder, the heart, lungs and other organs are not independent machines but are linked in their adventures with a nervous system and with a conscious mind which integrates their behavior in sickness and in health.

It is stupid to help a patient in one respect and hurt him in another. To give him good medicine but bad food would seem idiotic. But at present we do something as bad as this in many cases. We work hard to improve the condition of the sick man's body, but we allow conditions to exist which hurt his mind and through his mind check the healing processes. Mental and spiritual food is lacking. In long illness the mind usually starves or hungers, because man is not so one-sided a creature as our medical treatment assumes. We ignore the patients' view of hospital sights, sounds and smells, of the doctor's significant silences and half-heard conversations with assistants and nurses. We let poisonous fears act on his body and on his mind because no one stops them or neutralizes them. He fears death oftener than his doctor and his nurse realize because they know so well that his disease is not a mortal one.

The social worker might do the minister's work if she conceived her job in that way. But the social worker is so busy with the patient's economic problems that she does not know much about what is going on in his wandering, listless, frightened mind. She is afraid to touch religion because she fears sectarianism, proselytizing and conflicts with some particular branch of religion. Moreover, she is not trained for the minister's work.

Doctors, nurses, family, friends and the patient himself are too close to the situation to evaluate it comprehensively, and only the minister can weigh complaints dispassionately. Only he can see what is missing in the total set-up. Only he can inter-

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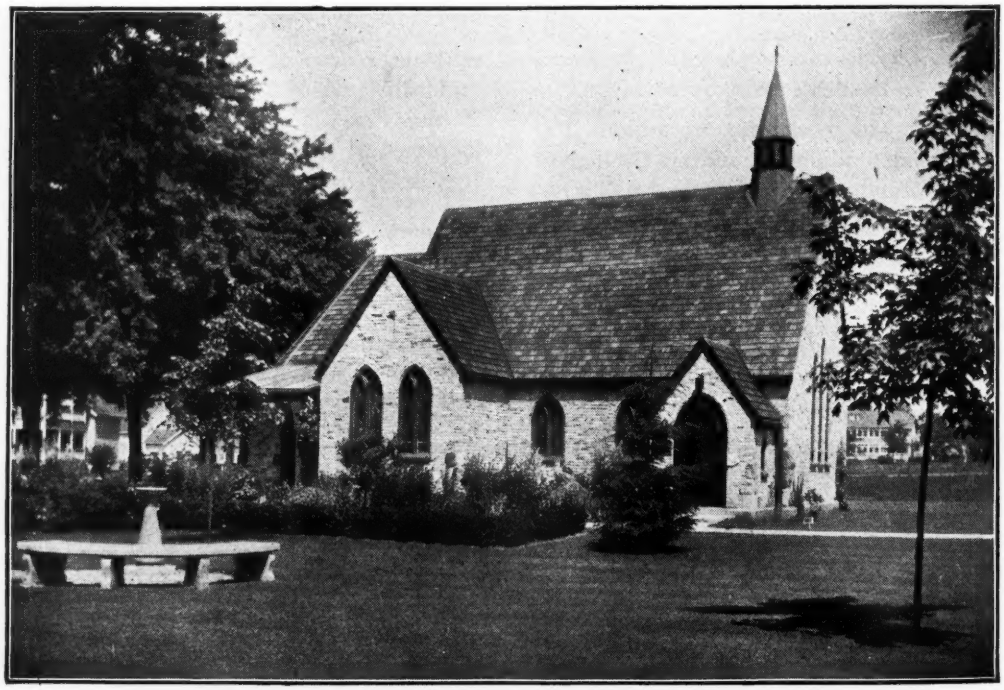

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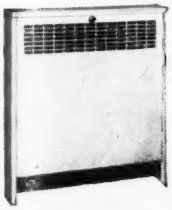

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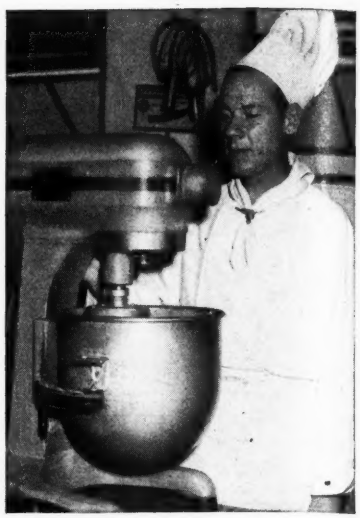

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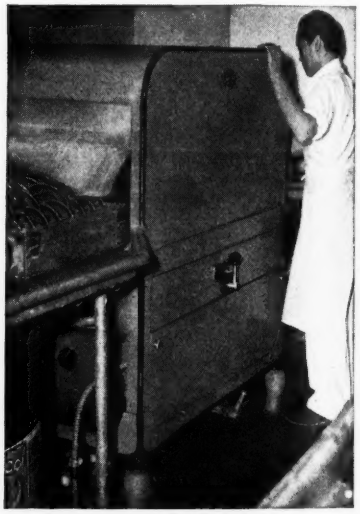

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Hospital Survey Reveals Present British Trend

A HOSPITAL survey known as the "Midlands Area Sur-Survey" has been completed by the Nuffield Provincial Hospitals Trust on behalf of the Ministry of Health. All hospitals other than mental hospitals were considered.

This survey is of interest because of the broad general principles which were woven into the report. The following are some of the points emphasized:

Site. New hospitals should not be erected in closely built up areas. Where a suitable site cannot be found centrally in the larger towns, general hospital accommodation should be provided in three parts: (a) a unit placed centrally in the town for outpatient and casualty work and for the treatment of emergency cases unfit for ambulance transport; (b) the main acute hospital situated on the periphery of the town; (c) a recovery hospital out in the country.

Hospital Districts. The area covered is to be formed into eighteen hospital districts as a basis of future hospital organization.

University Connection. The hospital in each region or area should be so planned as to have vital links with the medical teaching centre in the University of Birmingham. An intimate liaison of this nature is desirable for all hospitals in an area.

Construction. The pavilion type of hospital rather than the single block type is favoured. Hospitals should not be monumental and constructed for all time. Simple construction of semi-permanent type is adequate. A primary consideration is the facilitation in every way of the professional elements in the treatment of patients.

Transport. The present haphazard arrangement should be superseded by a pooled and centralized ambulance service with a central control bureau for the reception of calls.

The transportation of visiting relatives is of great importance. A ticket system might be instituted entitling patients' relatives to free or reduced rates of travel to hospitals by public transport services where these are available or otherwise by sitting cars of the ambulance service. This question of transportation is often used as a pretext to delay the entry of patients.

Municipal and Voluntary Hospitals. When there is a public authority and a voluntary hospital side by side, there should be (a) a division of function between the hospitals so that both shall undertake general medicine and surgery with an allocation of special departments between the hospitals instead of both running similar units; (b) there should be a single group of specialists on the staffs of both hospitals.

Rural hospitals. Cottage hospitals are a necessary part of an organized hospital service. They should not assume the functions of a general hospital; they are the periphery units in any hospital district served by a general hospital at the centre.

Infectious diseases. It is recommended (a) that hospital planning should aim at the elimination of all the smaller and little used infectious diseases hospitals; (b) that except when density of population justifies separate hospitals, treatment should be provided by units of general hospitals; (c) every infectious diseases hospital should be of such a size as to justify at least one resident medical officer.

Orthopaedics. Special orthopaedic hospitals for children are essential and are the only satisfactory means of treating orthopaedic patients. The treatment of adult patients in general hospitals is not desirable, in particular because long-stay patients become disheartened in a ward with patients whose progress is rapid.

Every general hospital should have a fracture department, including an outpatient section for ambulatory patients and follow-up cases. It should have a certain number of beds for short-stay inpatients while long-stay patients should be transferred to an associated orthopaedic hospital.

Allan Institute Takes Day Patients

Part of the Allan Memorial Institute of Psychiatry, Montreal, has been opened as a day hospital for patients who will come between 8 and 9 a.m. and take various kinds of treatment through the day, returning home again between 5 and 6 p.m.

Dr. George F. Stephens, superintendent of the Royal Victoria Hospital, of which the hospital facilities of the Institute are an integral part, has stated in connection with this development:

"We believe that this expansion of the facilities which the institute can offer will have several advantages . . . First, it will offer, to those who need it, more intensive treatment than can be given through the usual visits to the Institute's out-patient departments or to the doctors' offices. . . .

"A second advantage is that this new way of providing treatment avoids the problem which many patients have experienced who have been in hospital for an extended period, namely, that of adjusting themselves to living at home again. While this is by no means a universal experience, we often find that the patient who has been free of symptoms for some time before going home, will find the job of fitting into the home situation again somewhat of a strain.

"This, clearly, will be avoided if the patient spends every evening and night at home and thus never really losses contact with the home atmosphere. A third advantage, of course, is that in this way it be possible to offer medical care at a lower rate than where the patient has to be hospitalized throughout 24 hours."

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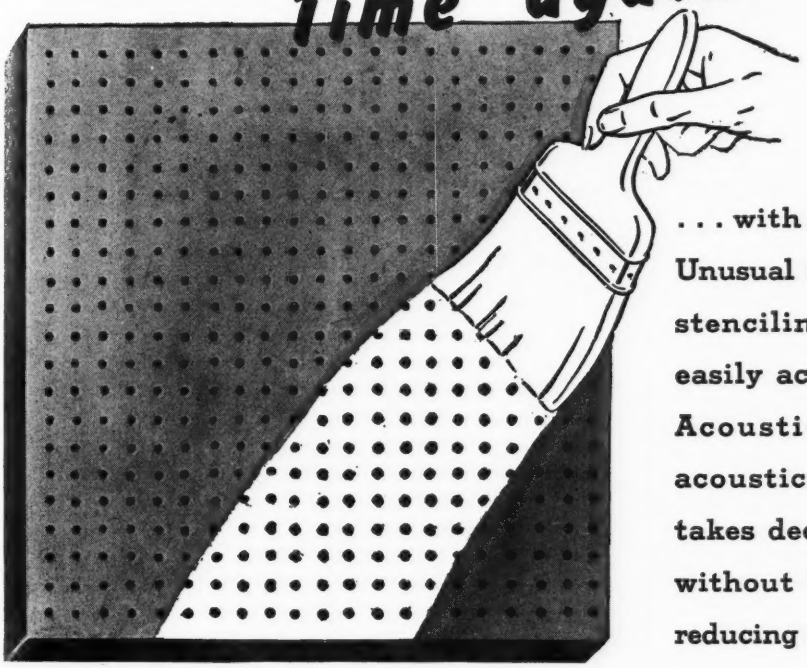

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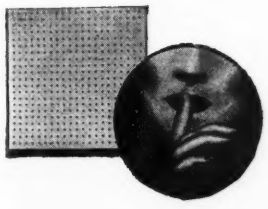

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Correspondence

Bargaining Agent? No!

To the Editor:

One morning in the Spring of 1927 when making rounds in the Hospital with the President of the Board of Governors a nursing sister passed by whereupon the President turned to me and remarked "I may not live to see it—but watch the nursing profession absorb all the characteristics of a trade union pattern". As a newcomer into the hospital field at that time and in the light of a layman's preconceived opinions of the nursing professioon, I must confess that I did not place much credence in this statement but when I peruse the observations under the heading "Should Nurses' Associations Act as Bargaining Agents?" in the May issue of "The Canadian Hospital" I am disposed to conclude the President's prophecy has come true; at least they are on the border line when the nursing associations and their leaders adopt the vernacular of unionism in such terms as "collective bargaining" and "bargaining agents", an imitation which I assume is intended to go beyond the boundaries of flattery. Has the mantle of Florence Nightingale become threadbare and is the new garb to be the slacks of Lewis? Will the day come when we shall stand on the curb to witness in the labor procession a float portraying a nursing sister standing at a bedside, exemplifying an "angel of mercy" but at heart a "collective bargaining agent?"

In the commentaries set forth in the May issue the retiring Chairman of your Committee on Nursing would seem to believe that these terms strike a harsh note and should not have a place in the nomenclature of nursing relationships and that its heretofore highly regarded professional dignity and standards should be preserved. No doubt the nurses have grievances and problems for adjustment, but is the voice of their claims to be articulated through their associations in union phraseology?

Of course, in these days of radicalism I suppose we must become attuned to new definitions and terms; at present the world is full of new bargainers who have hitched themselves to a freshly painted band wagon in order to herald in the tempo of modernity—sweet music for our financial salvation. I wonder?

Sincerely yours,

"W. R. Chenoweth"

Why Reg.N. Air-Hostesses?

To the Editor:

I have wondered why the airlines are allowed to drain the nursing profession as they are doing, by insisting that their hostesses be registered nurses. Nowhere else is this required. The United States lines do not require it and I noticed in the April issue of *Scottish Field* that the post of air-hostess was inaugurated on the Prestwick-Belfast run and that the first hostess was formerly a reception clerk in a hotel.

A few days ago T.C.A. announced that twenty-one nurses had completed their hostess training and another twenty-one were starting—all registered nurses. If that position were opened to any girl with the desired qualities it would certainly mean that more nurses would be available for the important task for which their four years of intensive studies has fitted them.

Sincerely,

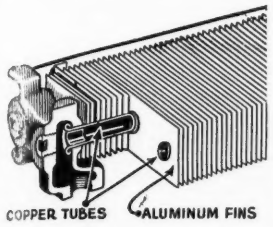
(Mrs. A. D.) Thérèse Leslie,
Indian Head, Sask.

Baby Wins $50.00 Prize in Hospital Day Competition

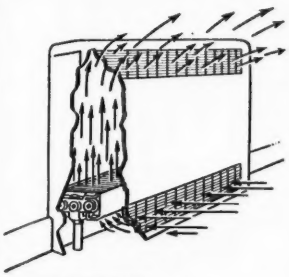
Babies, babies everywhere, but the prize awarded by St. Michael's Hospital, Lethbridge, at its National Hospital Day celebration was won by baby Doreen Marie Stafford of Carmangay, daughter of Mr. and Mrs. Armidace Stafford. The award is made annually to an infant born the previous year at St. Michael's Hospital and who is present and registered at the public reception.

More than 145 of the 458 babies born in the hospital during 1945 were at the function held this year as well as older brothers and sisters and approximately 300 adults. The Board of Directors and the Sisters of St. Martha of St. Michael's Hospital played host to the public during the afternoon. Conducted tours of the institution were arranged and a special room was set aside as a nursery for the care of visiting babies.

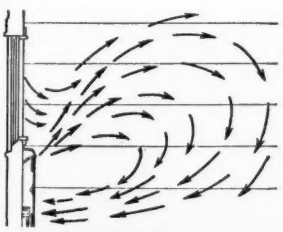
Here's the Inside Story!



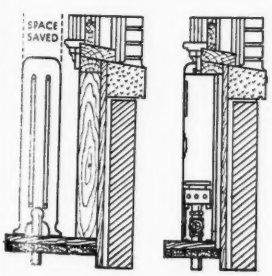
CUT AWAY SECTION of the Trane Convector-radiator heating element shows the construction and extended surface of the fins which are responsible for the added heating efficiency of Trane Convector-radiators.



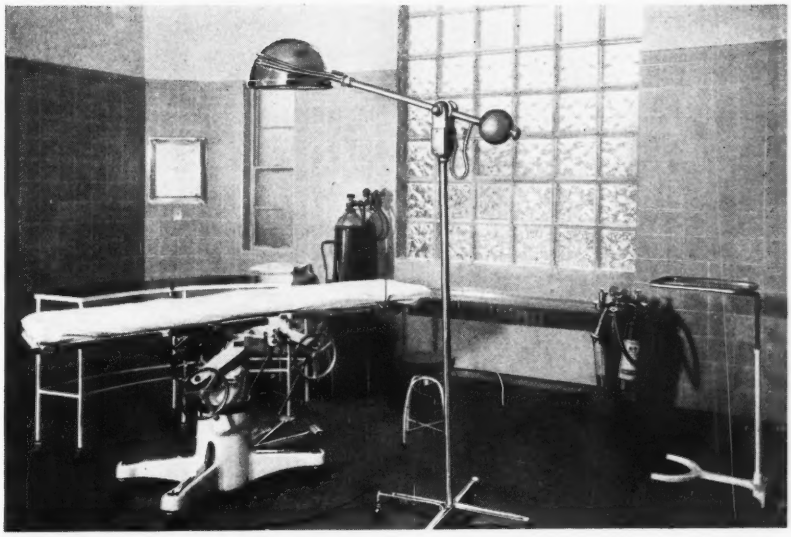
CROSS SECTION of Trane Convector-radiator Cabinet shows how the cold air is drawn off the floor, warmed and circulated in a continuous, smooth flow by gentle, natural air currents.



HEAT CIRCULATION provides even temperatures from wall to wall and ceiling to floor. Comfortable warmth with no trace of stuffiness. Furniture may be placed close to Trane Convector-radiators, if space is restricted, with no sacrifice in comfort.



COMPACT UNITS which fit snugly against the wall take a minimum of floor space. Full use of all floor area is available because all parts of the room are heated evenly.



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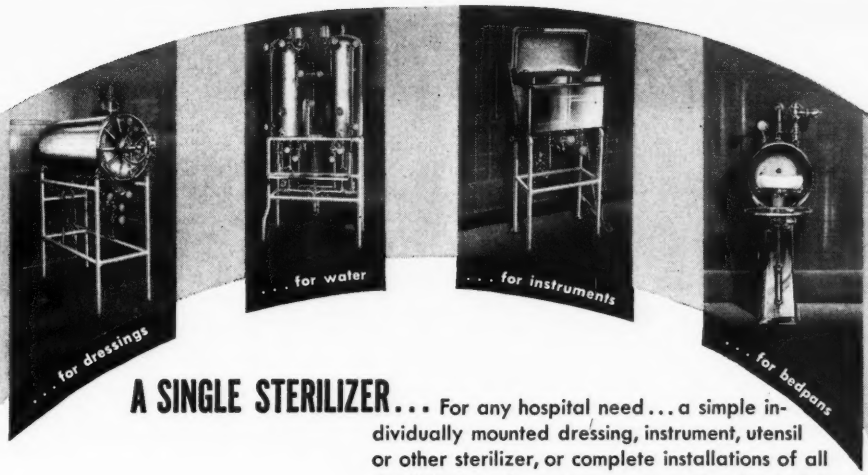

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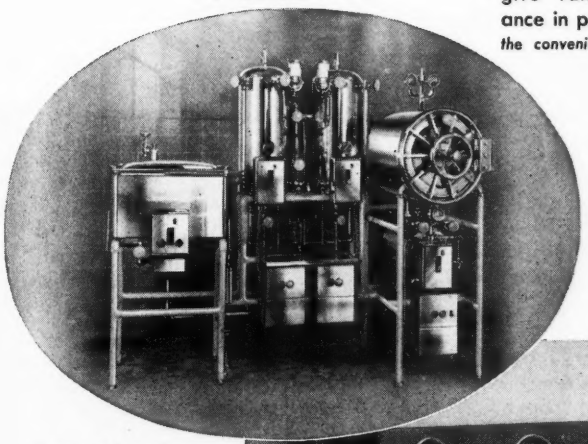

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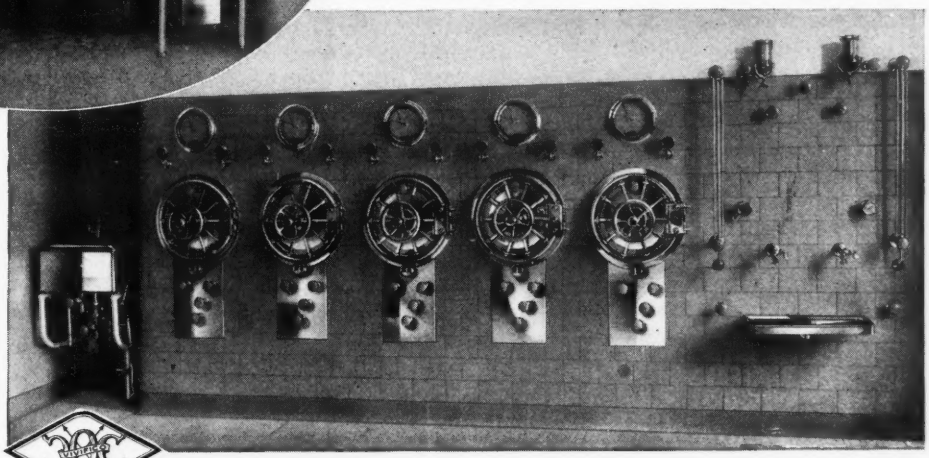

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Provincial Notes

(Concluded an page 72)

New Brunswick

AMHERST. To attract more nurses to hospitals, the Nova Scotia Registered Nurses Association at its annual meeting here decided to appoint a "laison officer" between hospitals and nurses' associations. The supervisor will establish a "better system of public relations" by keeping a close contact between hospitals and nursing branches.

* * *

DALHOUSIE. A modern 100-bed general hospital will be erected in Dalhousie by the Sisters of St. Joseph as soon as materials are available. The cost is estimated at $500,000.00. In the meantime the Andrew Wallace home here has been purchased and will be opened as a 20-bed hospital in September. This building will later serve as a home for hospital personnel.

* * *

EDMUNDSTON. A 150-bed tuberculosis hospital, which has been under construction at St. Basile since 1944, will be opened by the Religious Hospitaliers of St. Joseph this month. The building will include the main body of five floors and a three-storey wing for the kitchen department, an auditorium and a chapel. Cost of construction, including a heating plant and 1,100 feet of tunnel, is expected to exceed $1,000,000. Built of two-shaded buff brick, the sanatorium occupies a picturesque site on a mountain side in the St. John valley, overlooking the river.

A 200-bed general hospital is also under construction in Edmundston at a cost of $1,500,000. This is the Hotel Dieu of St. Joseph which is expected to open in September.

* * *

SAINT JOHN. In submitting the annual report of the tumor service to the board of commissioners of the Saint John General Hospital, Dr. John R. Nugent, tumor service surgeon recommended the provision, in the near future, of an emanation plant. He also pointed out that the hospital commission might consider the provision of more beds, advantageously located and serviced, for this type of disease.

Captain Harold J. Delaney, who has recently received his discharge from the R.C.A.M.C., has been appointed assistant superintendent of the Saint John General Hospital.

Quebec

SHERBROOKE. Construction of a modern ten-bed hospital with additional facilities for nurses and other staff has been started at Sherbrooke, shire town of St. Mary's Municipality. The hospital is designed to serve the municipality. Its site overlooks the beautiful St. Mary's river.

* * *

MONTREAL. Allan Bronfman was re-elected president of the board of administration of the Jewish General Hospital at a recent meeting.

* * *

SHAWVILLE. Plans have been completed for the new Pontiac Community Hospital which will provide 52 beds and cost about a quarter million dollars. This hospital is very important because it is the only one north of the Ottawa river between Hull and Rouyn.

Ontario

CORNWALL. Captain C. W. Hind, former catering officer in the Canadian Army, has been appointed business administrator of Cornwall General Hospital. His duties will include supervision of the purchase of all supplies and the conduct of the business office.

* * *

BRANTFORD. Dr. J. V. Nelles, who has been acting superintendent of the Brant Sanatorium since July, 1941, has resigned to enter private practice and will be succeeded by Dr. H. A. Minielly who has been assistant physician for the past three years.

OSHAWA. Excavation has begun for the new $90,000.00 nurses' residence at the Oshawa General Hospital. The new residence, which is a gift of Colonel and Mrs. R. S. McLaughlin, will supplement the present nurses' quarters, will provide 49 single rooms for nurses, common rooms, recreation facilities, and will also contain the superintendent's suite. This will be a three storey building in Georgian style with double hung windows and red brick exterior walls of fire-proof construction.

* * *

OTTAWA. The Salvation Army is conducting a campaign for $195,000 to be used for the construction of a 100-bed extension to Grace Hospital. Carleton County Council has approved a grant of $5,000 toward this project.

Extensions to the Royal Ottawa Sanatorium will include a new 130-bed infirmary, a power house and laundry section and a new service building, at a total estimated cost of $550,000. Plans for the new buildings have been approved and tenders for the first unit are being received.

* * *

OWEN SOUND. The tax-payers of Owen Sound have voted a grant of $300,000 and approved plans for the expansion of the Owen Sound General and Marine Hospital. The new building, which will cost approximately $500,000, will comprise a nurses' residence and several additional wards. It is proposed to open a nurses' training school when construction is completed.

* * *

SUDBURY. St. Joseph's Hospital celebrated its 50th anniversary in June. The Sisters of the Grey Nuns of the Cross, founders of the hospital, are able to look back upon a half century of achievement in the healing of the sick in this district. The modern, highly specialized 215-bed hospital is a far cry from the original building which was an old house converted to accommodate 32 patients. The work of the hospital has been greatly enhanced by the addition of the most up-to-date x-ray and laboratory facilities. A modern physiotherapy department is also maintained.

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Provincial Notes

(Concluded from page 68)

Manitoba

PORTAGE LA PRAIRIE. A new ambulance has been donated to the Portage Hospital by the Lions Club of the district. The vehicle, which was purchased from the War Assets Corporation, is a two-stretcher ambulance complete with special crash equipment.

* * *

SELKIRK. The Selkirk General Hospital staff does not wish to boast but they appear to have set a baby record. Between 11.15 p.m., Friday, May 17 and 8.40 a.m., Saturday, six babies, one boy and five girls, were delivered in the hospital case room. Nurses and physicians were kept busy during those nine hours.

* * *

WINNIPEG. Following twenty-five years as Superintendent of Nurses at the Winnipeg Municipal Hospitals and 33 years as a member of the staff, Miss Elsie Robertson completed her term of service a few weeks ago. Miss Robertson enjoyed an outstanding reputation in the field of nursing education and during her years as superintendent of nurses more than three thousand student nurses came to the Municipal hospitals from affiliated schools in the western provinces for training in the care and treatment of communicable diseases.

Saskatchewan

CENTRAL BUTTE. Acquisition of airport buildings will mean improved hospital facilities for the Central Butte and Lucky Lake communities. Central Butte has obtained the former officers' quarters building at the Davidson airport for a hospital, while Lucky Lake has purchased the hospital building at Caron airport. Arrangements are being made to move the buildings. Central Butte now has an 8-bed hospital and with this new addition its capacity will be increased to 20 beds.

* * *

GRENFELL. The new 17-bed Grenfell Union Hospital has been officially opened. It contains a modern operating room, x-ray department, sterilizing room, case room, nursery and isolation wards as well as three-bed and two-bed general wards and one private room. The wards have been furnished by the Masonic Order, I. O. O. F. and the I. O. D. E.

* * *

MOOSOMIN. Residents of the new Moosomin Hospital District have been asked to approve the erection of a new wing to the present hospital building. The money for this project is now on hand, a gift from the Moosomin General Hospital Board, and by voting in favour of it, the people are simply giving themselves a new hospital free. There will be no debentures to increase taxation. The sum of $65,000, which is the amount required, has been given free, in cash, to the Union Hospital Board.

Alberta

EDMONTON. The Edmonton Military Hospital, formerly a Jesuit College, has been turned over to the Department of National Health and Welfare. This structure was purchased during the War by the American Army which used it as headquarters for the Northwest Service Command. When it was declared surplus by the U.S. Government, it was taken over by Ottawa and converted into a hospital for veterans suffering from tuberculosis. Accommodation for 100 veterans will be retained until space can be arranged elsewhere. Henceforth the institution will be a sanitorium for the care of tuberculous Indians, known as the Indian Health Service Hospital. Dr. Herbert Meltzer, formerly surgeon at Manitoba Sanatorium, Ninette, is in charge.

* * *

KILLAM. The new $70,000.00 wing of the Killam General Hospital was officially declared open at a civic ceremony on May 17th and over 600 people inspected the building. The wing contains 16 beds, 6 cribs, a fine nursery and a modern operating theatre. This brings the total capacity of the hospital up to 28 beds exclusive of accommodation for babies.

* * *

OYEN. The new 15-bed Oyen Municipal Hospital, which cost approximately $59,000, has been officially opened. Dr. I. Harden is in charge of the hospital and Miss Gorden Hartwick is matron.

British Columbia

CRANBROOK. The Ladies' Aid of the St. Eugene Hospital has contributed over $601.00 to the hospital for the purchcase of a gas kineneometer distending machine.

* * *

LANGLEY. As a culmination of four years' effort on the part of the Langley Hospital Committee, a by-law is being presented for the approval of the tax-payers which would provide for the construction of a 37-bed cottage hospital at a cost of $120,000. The Provincial Government will contribute $31,600. The hospital as planned would be a one-storey, slow-burning structure with a modern operating room, x-ray room and maternity section.

Premature Babies' Rooms

Special conditions are needed for premature babies' rooms. Frequently a temperature of at least 80°F. to 85°F. is required and it is considered important in some instances that this temperature should be maintained within a very close range. On more than one occasion the writer has been asked to design heating which should be capable of maintenance within 2°F. for this type of room. Humidity also plays a very important part and it is thought well that a special humidifier should be fitted to give the degree of moisture laid down by those in charge. As the size of the rooms in question is generally relatively small and does not warrant the installation of extensive mechanical equipment the writer is of the opinion that the heating and ventilating of these rooms should be done by electronical methods which lend themselves very readily to great flexibility and very accurate control.

—H. A. Sandford, Consulting Engineer, "The Hospital," March, 1946.

The Windsor Tornado

(Concluded from page 31)

pleasant personality. With these attributes, much difficulty can be surmounted.

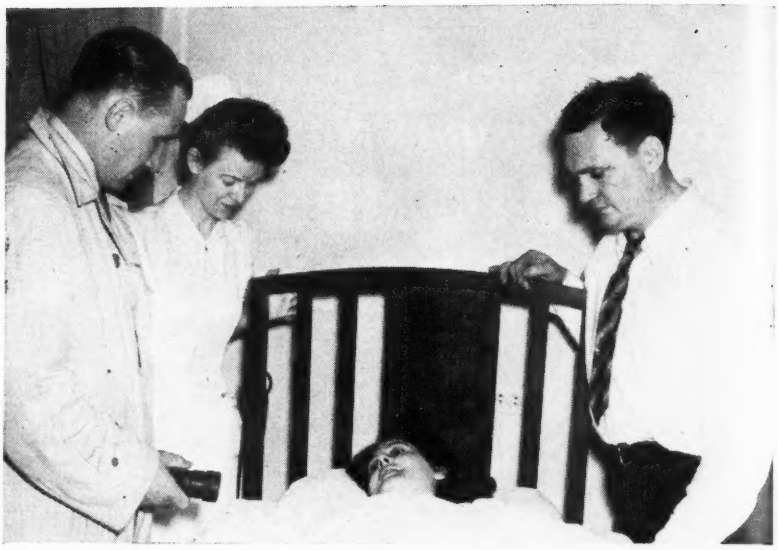
"The entire hospital staff should be trained to report to the hospital immediately in the event of a disaster in a community. In any event, they should be instructed to communicate by telephone to see if they are required."

Major Barr goes a step further. "One thing stands out like a signpost in the midst of this catastrophe: Some system of co-ordination ought to be effected among the doctors and medical services of the city, such as was used during the war by the A.R.P. After telephonic communication ceased, our hospital was virtually isolated."

For those who toiled so valiantly during that terrible night, all three hospital heads have nothing but the highest praise.

Says Major Barr: "Let me add a word of heartfelt commendation. The devotion to duty of staff surgeons, interns, nurses and all others that night is above praise. It was a revelation."

"Our personnel deserve special mention," reports Mother Maitre. "All volunteered. No one was in anyone's way. All proved ingenious in appearing where most needed."



Mayor Arthur Reaume, left, visited all the hospitals. Mr. Horace Atkin, on the right, seems pretty tired and dishevelled.

And Mr. Atkin adds: "Without the co-operation of our entire staff, industries and neighbours, we could never have cared for so many injured. I believe that every patient who entered hospital received the best possible medical attention, notwithstanding the difficulties encountered.

"We have learned, also, that the people of a community are the friends of the hospital, and will do anything and everything to help. We hope that we shall not again have to call upon them, but if we do we are confident of the response we shall receive."

Citizens Rescue Squad for Drumheller Hospital

(By Mr. L. Wilson, Sec.-Treas., Drumheller Hospital in the "Annual Report for 1945-46" of the Alberta Municipal Hospitals).

All hospitals in the province have fire drills regularly and keep their fire fighting equipment in good condition, but is this enough? For some time past the Drumheller Board has given serious thought to the problem of removing bedridden patients or fresh operative cases from hospital in case of fire occurring at night—say between the hours of 9 and 12 p.m. A skeleton night staff only is on duty and if the fire is such that the immediate removal of six or seven patients is imperative, the night staff cannot cope with the emergency and outside help is necessary even before the arrival of the fire brigade. Where is it to come from? Drumheller thinks the answer is in the organization of a rescue squad from residents adjacent to the hospital. The details may be of interest.

A meeting of the residents in question was called and it was decided to enrol five squads of four men, each squad to be headed by a captain. One squad was assigned for work on each of the three floors of the hospital and two for duty at the bottom of the fire escape or at such outside locations as indicated to get evacuated patients to shelter. The outside squad would work in conjunction with the two local ambulance owners, the use of whose equipment is pledged. A siren is to be purchased and used to signal the alarm when necessary. It will be installed on the roof of the hospital. It will be electrically operated and a push button will be located on each floor. The signals will be distinctive and easily audible to squad members who live near by. Two practices have been held. The first was an inspection to familiarize the squads with the layout of the building, the location of fire extinguishers, etc., and exits. The second was a regular fire drill, during which two "patients" were removed and sent down the chute.

Regular drills are planned until a degree of efficiency is attained and then a drill in conjunction with the local fire brigade is to be held. The plan seems to be working satisfactorily.

Chief Dominion Analyst Retires

The Honourable Brooke Claxton, Minister of National Health and Welfare has announced the retirement of J. G. A. Valin of Ottawa, Chief Dominion Analyst, after 45 years in the public service. Dr. C. A. Morrell of Ottawa, assistant chief, has been named acting Chief Dominion Analyst.

Admissions

(Concluded from page 39)

pertinent information than if a printed form were used.

Quite often a patient is reluctant to give his various residences, not knowing the reason for such questions. This reticence can be overcome by an explanation of the purpose. In fact, if a patient hesitates in answering any question, a frank explanation of the reason for it will usually result in an answer.

Sometimes when a patient is asked what amount he wishes to pay he will name a sum entirely beyond his means. This is only natural because the patient feels that a promise to pay an account quickly will save his being "pestered" by the hospital authorities during his stay. Or the patient may conscientiously feel that he can pay such an amount, forgetting that he has other obligations to meet.

Many people on entering hospital wish to give the impression that they are well able to pay their way and can therefore demand the best in accommodation. Strangely enough such people, when leaving, so often endeavour to give exactly the opposite impression—that they cannot possibly pay!

If a promise is made by a patient to pay an amount obviously in excess of his ability, the admitting officer should diplomatically draw his attention to the fact and suggest lower payment. There is good common sense in this reasoning because the patient, under such circumstances, will do all in his power to make regular payments of an amount which is within his ability to meet.

Discharge Procedure

When a patient is discharged, the business office—which is usually also the admitting office—should be advised in sufficient time to have the account made out. The nurse should bring the patient to the business office, and a cheery word by the secretary will often be an inducement to the patient to pay his account as originally arranged.

No patient should ever leave the hospital without a hospital account, except where a third party is responsible.

Even though a pleasing impression of the hospital is gained upon admission, such impression can be nullified unless kindness and tact are exercised by the secretary at the time of discharge. It is therefore just as important to observe the same thoughtfulness and common sense in dealing with the patient upon his discharge as upon his admission.

Upon the discharge of the patient it is not necessary to remind him of any promise he has made to pay monthly instalments; on the contrary avoid any mention of the financial arrangements previously made. By adopting such an attitude you convey to the patient your complete confidence in his promise to fulfil his obligations to you.

Saskatchewan Health Appointment

Premier T. C. Douglas of Saskatchewan has announced the appointment of Dr. Frederick D. Mott, B.A., M.D., C.M., L.M.C.C., as chairman of the Health Services Planning Commission. Dr. Mott, who is a graduate of McGill University, has lately been associated with the U.S. Public Health Service and has had wide experience in setting up medical care programs in rural areas.

Hospitals in Britain

(Concluded from page 50)

student is not so much a system as a series of principles. In the end his success as an administrator will depend on his personal qualities and his wisdom." Nevertheless his paper envisages the creation of a grade of "administrative medical officer" (A.M.O.). He recognizes that medical administration will involve something wider than hospital administration and that a recognized course of academic training will need to be followed by practical experience through an apprenticeship system.

It will be appreciated from these suggestions that Professor Mackintosh is a fresh thinker who looks ahead, and other people may not be able to keep pace with him. But he has a helpful mind which grasps the requirements of the situation with a view to finding a practical solution. In this subject he has certainly found one of the principal contributions to the efficient working of the new health organization, when it has been forged on the anvil of Parliament.

Here and There

(Concluded from page 52)

played? . . . What do clean sheets in a soft bed feel like?"

Bethune travelled 3,615 miles during the year, performed 762 operations and examined 1,800 wounded, as well as organizing the army's sanitary service, writing text books and establishing a medical training school. What infinite capacity for work and for organization! An accidental infection while operating was responsible for the spreading septicaemia to which he succumed.

Here was a man of boundless creative ability, combined with an absolute hatred of stupidity and injustice. His impatience with dullness and conservatism doubtless caused him to give up the conventional pattern of a physician's life. He was a radical, using the word in its best sense, going directly to the root of things both in his work and in his sociological studies. While lavish in his friendships, he expected the same generosity in return. His personal book-plate *'This book belongs to Norman Bethune and his friends'* is indicative of this attitude.

It is probably true that the impact of Bethune on Canadian medicine was too brief and too parochial to achieve what he might have wished but perhaps the profession as a whole might be enriched if more physicians could find the courage which this man displayed. His lode-star was the re-shaping of medicine into a more effective instrument of society. That he would have put his whole weight behind some effective form of national health insurance is a foregone conclusion.

We have tried to present to you a man who was not only a physician but also a painter, a writer, an inventor, a visionary, a believer in the man-on-the-street and one who practised the Golden Rule. The final stanza of his poem "Red Moon" reflects his passionate faith in mankind:

To that pale disc we raise our clenched fists
And to those nameless dead our vows renew.
"Comrades, who fought for freedom and the future world,
Who died for us,—we will remember you."

Pastor and Patient

(Concluded from page 56)

pret the efforts of each actor on the stage.

The clergyman's first concern in the sickroom should be to do no harm. Working within this caution he can be of significant help in the patient's recovery, if peace of mind and renewed confidence can be said to contribute to the recovery of health, and most medical men hold that they do. If the patient is not to recover, the clergyman can be of help in aiding the patient and his family through the trying experience of death.

Granted that the minister is alert to the possibility of doing harm in the sickroom and is careful to avoid it, the questions of interest to physician and patient are: How does the minister go about his work in the sickroom? What is his attitude? Is he different from the other professional workers, i.e., the physician, the nurse, the medical social worker? Is he only a visitor or more than a visitor?

The clergyman's interest and purpose in the sickroom may be stated in the simplest form as being a desire to aid in the recovery of health in any way possible and to aid in the spiritual growth of the sufferer.

Pain, fear, bitterness, guilt, worry and loneliness, all of which are frequent visitors in illness, have their effects upon the religious outlook of the ill as well as upon recovery. Many patients have setbacks when the only cause that can be discovered is annoyance at a caller, bad news, a book they have been reading or some similar external stimulus.

Work with the sick is highly individualistic, slow and time-consuming. Every person tests the wit, intelligence and imagination of the minister. Each patient must be accepted as he is at that time and each succeeding time when he is seen. His past experience, his limitations, his prejudices, his ideas, his humor, his imagination, his hopes, his affections and loyalties, must be accepted and utilized. The minister's task in working with the sick is not to induce the other person to believe as he does, although that may be a result; it is to aid the sufferer to move forward according to the patterns of his own life.

The pastor is not a casual visitor. He should consider himself as a professional worker disciplined and trained with specific methods at his command and accumulated experience behind him. He may visit with a patient just as the physician may visit, but his eyes are always focused upon the patient's greater need and he is trained to recognize signs of restlessness, apprehension and worry. His method reaches its climax when, through prayer adapted to each patient's need, he directs the sufferer's attention to specific objects and ideas, and turns restlessness into other channels.—*Selected.*

A peace which is likely to be lasting must be conceived in intelligence, derived in a spirit of compassion for man's welfare and security, and maintained through some form of dynamic instrument for international collaboration and co-operation.—*Dr. James A. Crabtree.*

Excellent Program Planned for Manitoba Institute

Plans for the Institute on Administration sponsored by the Manitoba Hospital Association are shaping up well, and from present indications the success of this pioneer effort on the part of the Association will be well worth the time being spent on its preparation.

Outstanding hospital leaders who will act as members of the faculty include Dr. Malcolm T. MacEachern; Mr. A. J. Swanson; Dr. Harvey Agnew; Mr. Percy Ward, Chief Inspector of Hospitals for British Columbia; Mr. S. N. Wynn of the Yorkton General Hospital Board; Dr. A. C. McGugan, President of the Associated Hospitals of Alberta; and Judge J. M. George, Chairman of the Advisory Commission under the Health Services Act of Manitoba. Officials of the Provincial Department of Health and of prominent educational institutions will also be included in the faculty.

Membership will be limited to one hundred persons, and more than half that number have already made application. All those who enrol are requested to state their preferences with respect to subject matter for discussions and hospital tours, and these preferences will play a very important part in the final drafting of the program.

The Institute will be conducted in the Royal Alexandra Hotel, Winnipeg. A list of hotels and rates will be furnished upon request. Complete information regarding the Institute may be obtained from:

Mr. Donald M. Cox,
Winnipeg Municipal Hospitals,
Morley Avenue East,
Winnipeg.

C.S.L.T. Holds Annual Meeting

The 1946 convention and annual meeting of the Canadian Society of Laboratory Technologists was held at the Royal York Hotel in Toronto, Friday, May 31st and Saturday, June 1st. A series of excellent addresses were given and a round table conference led to animated discussion of various problems of current interest. At the business meeting on Saturday, officers for the coming year were elected. These are as follows:

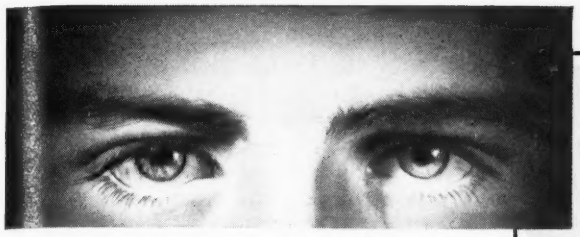
President—Mr. George Darling, Nanaimo, B.C.

Vice-President—Miss Ileen Kemp, Saskatoon, Sask.

Secretary—Miss Helen L. Smith, 286 Victoria Avenue N., Hamilton, Ont.

Health is vital to life, for when health is entirely lost life dies. It is vital to happiness, for with ill health as his heritage, living becomes a burden that man can scarcely bear. It is vital to success, for whether ill health be desperate and lethal or merely petty and nagging, it is costly, strength-sapping and dangerous. Yet it is a strange fact that though people will plan for everything under the sun from new clothes for the children to a new house for the family, they seldom plan for health. Why not? Is it because of failure to realize the value of their health until they have lost it? Or is it because they don't know how to plan for it?

—Mr. C. C. Evoy, Department of Public Health, Alberta.



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MURINE is a buffered, isotonic solution, and can be used without fear of irritation to the conjunctiva or cornea. The pH of the Murine formula, approximately 8.0, together with the isotonicity of the tears, fulfills all the more modern desiderata of a collyrium in that it is soothing, cleansing, and non-irritating.

The ingredients contained in the Murine formula are: Potassium Bicarbonate, Potassium Borate, Boric Acid, Berberine Hydrochloride, Glycerine, Hydrastine Hydrochloride 'Merthiolate' (Sodium Ethyl Mercuri Thiosalicylate, Lilly) .001%, combined with Sterilized Water.

Boric Acid is advantageously used in a low concentration (1.4830). A higher percentage, in combination with the other salts present, would cause Murine to be hypertonic to the eye and therefore lose its soothing effect and produce symptoms of mild congestion and irritation.

The ingredients, Potassium Borate and Potassium Bicarbonate, are mildly alkaline and serve as a detergent and mild astringent. They act synergistically with Boric Acid, which is mildly antiseptic.

Glycerine is used for two specific purposes: 1—it adjusts the Murine solution to the exact isotonicity of the tears: 2—it keeps the conjunctiva moist.

Berberine serves a very useful purpose. It has been known for many years that the alkaloid Berberine in alkaline solutions is an effective therapeutic astringent on inflamed and catarrhal conditions of the mucous membrane. The therapeutic effect of Berberine on mucous membrane is supplemented by Hydrastine Hydrochloride. To the above, a 1% solution of 1-1000 of 'Merthiolate' is added since it was found by practical experimental research in our laboratory that this solution was sufficient to inhibit mold growth.

The method of compounding these previously mentioned ingredients eliminates all side reactions together with the formation of any unlooked-for chemical realignments, thereby guaranteeing the true and unadulterated percentages of the formula as a final product.

THE FORMULA OF MURINE is in keeping with the dictates of all the recent desirable factors necessary in a collyrium: it is isotonic with the tears, it is a truly buffered solution, it includes mild but effective astringents, and a preservative. This all makes for a soothing, cleansing, and still uniquely therapeutically effective preparation for minor irritations of the eye.

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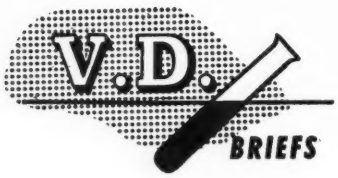

Promiscuity—A Psychiatric Study

The most recent contribution to the control of venereal disease comes from the field of psychiatry. Evidence presented in "An Experiment in the Psychiatric Treatment of Promiscuous Girls" carried out in San Francisco indicates that the application of psychiatric and social work techniques may be a signal advance towards the solution of the venereal disease problem.

An intensive study of 365 patients, all promiscuous or potentially promiscuous, between the ages of 18 and 25, led to the determination of suitability and desirability to consider psychiatric treatment. Of the original group, 299 were considered suitable for and willing to accept the treatment offered.

In the treatment the first step was to help the patient deal with the more superficial and material aspects of her problem. The patient was then given advice and, where necessary, assistance in troublesome home and family problems. She was also advised with respect to occupational and recreational activities.

In addition the psychiatric worker functions as a sympathetic counsellor to the patient. This was an extremely important factor in that many of these patients had no one else in whom they could place trust.

The appraisal of the results of treatment presented many difficulties, but as outlined, were interesting and encouraging. Six months from the date of commencement of treatment was taken as a fixed period over which to ascertain the degree of success, which was measured in diminuation or cessation of promiscuity.

Complete follow-up was achieved in only forty per cent of the treated cases. Of these, ninety per cent were known to have shown marked improvement with reference to promiscuity. Fifty per cent of those checked were stated to have stopped sexual contact entirely except within marriage.

A study of the motivation of promiscuity discredited two hitherto widespread beliefs, i.e., financial gain and sexual desire. Other explanations, therefore, had to be discovered. The chief common denominator in the personality of promiscuous women was found to be emotional immaturity. In the occasionally promiscuous group affection or circumstances played an important part while in the habitually promiscuous, the girl was generally found to be either in the throes of an emotional conflict, dependent by nature or grossly maladjusted. To her, promiscuous sexual conduct was a method of gaining the security that she lacked.

From a study of these motivating factors it was postulated that personality adjustment and psychiatric treatment would be of extreme value in the prevention of venereal disease.

A more thorough grasp and application of preventive procedures than now exists, can lighten the care exacted both from clinics and from hospitals.—*John Lawrence, M.D.*

And if you mean to profit, learn to please.—*Churchill.*

Associated Medical Care Plans

A national non-profit organization. Associated Medical Care Plans will include all state and local medical care plans that comply with the minimum standards for medical care plans approved by the Council on Medical Service and Public Relations of the American Medical Association. The authority granted by the State permits the new corporation "to promote the establishment and operation of such non-profit, voluntary medical care plans throughout the United States and Canada as will adequately meet the health needs of the public and preserve and advance . . . the high quality of medical care rendered by the medical professions of the two countries". The corporation recognizes that state and local medical care plans should be autonomous, but holds that the welfare of the public would be advanced by co-ordination of methods, coverages, operations and actuarial data.

The Commission of the corporation is directed to promote:

(a) Research and compilation of statistics.

(b) Consultation and information services, based on contacts with existing and contemplated plans, concerning administrative policies and procedures.

(c) Public education by interpreting the national scope and significance of the medical care plan movement, with publicity methods suitable to the various groups yet consonant with proper professional practices.

(d) Co-ordination and reciprocity among plans with respect to the transference of subscribers and benefits in the development of national enrolment among large enterprises and authoratative contacts with governmental or national agencies.

—*Public Health Economics, May, 1946.*

VITREOUS CLAY SANITARY EQUIPMENT

Engineering Representative of leading British Manufacturer of Sanitary Equipment in Vitreous Clay, Fireclay and Earthenware specializing in Hospital Requirements will be honoured by opportunity to submit tenders to Canadian Institutions planning new construction and modernisation. **Immediate deliveries are being made when special considerations necessitate.** Box 332, The Canadian Hospital, 57 Bloor St. W., Toronto 5, Ont.

SUPERINTENDENT WANTED

500-bed hospital, Victoria, B.C., invites applications from medical men for position of Superintendent. Administrative education, experience required, salary open. Address full particulars marked "Executive" to Secretary, Royal Jubilee Hospital, Victoria, B.C., before September 30th.

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JULY, 1946

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